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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

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Applying Visual Methods in the Conduct of Staff Conferences

By CHRISTOPHER G. PARNALL, M.D.

Medical Director, and

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TEN years ago the staff conference became one of the requirements for the approval of hospitals by the American College of Surgeons, when it was made one of the major articles of the minimum standards. Ever since that time numerous medical groups have made contributions to the discussion of the subject but even at the present time there is no unanimity of opinion in regard to the manner in which such conferences should be conducted.

As a result of the experience in our institution in this field during the past eight years we have learned some of the things that should be avoided and have hit upon some features that have proved successful in the conduct of these conferences.

The first point that has made itself evident to us is that the conduct of these conferences is a joint responsibility of the hospital administration and the medical staff. In fact, it seems that the only way in which the success of staff conferences can be assured is through the provision of funds, adequate facilities and personnel, by the hospital administration. Without some such provision the staff conference is almost certain to die out after a short time. Few hospitals have regarded staff conferences as of sufficient importance to warrant administrative support and fewer still have ever thought of providing the necessary financial support.

We may summarize the thoughts of the various writers on this subject, during the past ten years, in the following outline:

1. Stimulate the best type of scientific medicine in hospital practice.
2. Develop group consciousness, thus promoting cooperation.
3. Serve as a basis for postgraduate medical education for all types of staff members.
4. Check incompetency, ignorance and carelessness.
5. Promote the securing of autopsies.
6. Prevent unnecessary surgery.
7. Check up infections, consultations and end results of treatment.
8. Periodically appraise clinical experience and review critically the work of all departments.
9. Inaugurate preventive measures against infections and complications.
10. Discourage multiple hospital affiliations.
11. Cultivate sympathetic attitude of the staff towards the administration.

The individual staff member has no opportunity to see the work of the hospital as a whole or to become familiar with the problems of the institution except through the staff conference. Modern medical practice has become a large cooperative enterprise and nowhere is cooperation more essential than in conducting the staff conference. This conference should be conducted primarily for the professional advancement of the staff, and when this thought is grasped and the proper spirit permeates the conference its success is almost assured. It has been felt by many writers that if the staff members give proper support to

the conferences of one institution they will have little time to spend in multiple hospital affiliations.

There is practically no limit to the amount of material available for staff conferences. It should be confined, however, to actual cases and problems of the institution in question and it should not be primarily clinical in nature.

Among the proper subjects for discussion may be mentioned: any cases containing practical lessons; studies of series of cases illustrating the success or failure of laboratory methods, x-ray diagnosis, operative interference (follow-up studies); reports of departments—clinical laboratory, x-ray department, record department; reports of deaths, unimproved cases, infections, operations, deliveries; general monthly statistical summary; report of incomplete records; analysis of good records; demonstrations of special technical procedures used in the hospital; discussion of selected deaths that have come to autopsy; needs of various clinical departments; criticisms of laboratory work or facilities and care of patients; problems of the various hospital departments.

Summary Sheet Is Recommended

It should always be remembered that these conferences should be of practical value to the staff, for it has been our experience that physicians will voluntarily attend conferences just as long as they learn something.

The monthly statistical summary sheet issued by the American College of Surgeons is especially to be recommended for use in these meetings, since it offers a method of presenting a large amount of essential data in a short period of time.

It is essential that a regular committee be appointed to have charge of the preparation of programs. We have a small committee consisting of the medical director, his assistant, the chairman of the staff conference, the chairman of the medical board and three of the most energetic staff members who represent the departments of medicine, surgery and pediatrics. This committee represents the major departments of the hospital and their chief interests. Its main responsibility is to provide for the meeting a program so interesting and profitable that no staff member will feel he can afford to miss it. The committee meets about two weeks before the time of calling a staff meeting, selects the cases for discussion and outlines the program. The program is mimeographed and a copy is mailed to all members of the staff one week before the date of the meeting.

The selection of the chairman of the conference is a matter of great importance. He must command the respect of the staff through his knowledge of the broader aspects of medicine and

surgery and he must be an energetic and competent presiding officer who will encourage discussion and who will not allow any suggestion of acrimony to enter into the debate. Above all, he must be one who will not tolerate any suggestion of personal attacks among the members. Such a presiding officer is difficult to find.

For the purpose of making the discussion of deaths more stimulating we are finding the so-called "Cabot plan" very successful. Abstracts are given to two staff members who have never seen the cases (one an internist and the other a surgeon), a week before the meeting. These members open the discussion and, following this, general discussion is encouraged. The roentgenologist shows the x-ray plates and discusses his findings and finally the pathologist gives his findings and diagnosis. In conclusion the chairman reads the diagnosis that has been written on the summary sheet of the record. This method suffices to humble the most self-confident member of the staff and calls attention in an effective manner to deficiencies in the case records and failures in the methods used in studying patients. One of the greatest advantages of the method lies in the fact that no one knows the names of the patients or the names of the physicians who treated them.

Each staff member records his own attendance by signing a small card and depositing it in a box near the door. This saves time, avoids confusion by making it possible for a number to register at the same time and promotes accuracy in keeping the attendance record. The absence or presence of each member of the staff is recorded on large sheets of paper kept on a special bulletin board in the staff room. Thus it is possible for each one to see at a glance whether he belongs to the group of members who are supporting this particular hospital activity. Personal pride has been found to be a potent factor in promoting attendance.

Advantages of Visual Methods

For the past three years we have been applying visual methods with considerable success in the conduct of all of our hospital conferences—forty weekly clinical conferences and ten monthly staff conferences each year. The method consists in projecting upon a twelve-foot screen resumés of case records, statistical summaries, charts, diagrams, photographs of patients and specimens and other material pertaining to the cases. This method saves much time in case presentation, avoids unnecessary questions (since all of the details are constantly before the audience), makes possible the simultaneous demonstration of specimens and charts to the audience, and, finally, makes possible the best utilization of time by

spending it in the discussion of important cases.

In using this method it is essential that a large, well illuminated screen be used, that the photographic technique be flawless and that the material be arranged in such a way as to secure the greatest visibility.

In order to keep the conference moving (which, in fact, is one of the secrets of its success) it is necessary that the chairman have some method of limiting the time for discussion. We have accomplished this by using a buzzer that can be heard throughout the room. In the presentation of a case a warning is sounded at the end of four minutes and two signals terminate the presentation at the end of five minutes. Three minutes is allowed for each individual discussion. By discouraging loose thinking and still more loose talking this method provides the best sort of training in the presentation and discussion of cases.

How to Make Conference Successful

Our own experience in conducting staff conferences has emphasized the following points, which we present as special recommendations:

Individual staff members must approve and agree to support the objects of the staff conference; it must become a voluntary "Staff Rule."

There should be a staff conference committee to study records and make a selection for discussion and to prepare a list of pertinent questions to serve as a basis for debate.

Cases selected for discussion should present problems of general medical and surgical differential diagnosis and treatment.

Administrative problems should not be discussed at the staff conference.

An attendance card must be signed by each member present.

Support of staff conferences should be an important factor in staff promotions.

There should be a time limit for presentation (five minutes) and for individual discussion (three minutes) of each case.

There should be separate staff, clinical-pathological, departmental and general clinical conferences.

Clinical and staff conferences should be the responsibility of the chief resident physician and provision should be made in the hospital budget for personnel and equipment.

Support of staff conferences should be insisted upon by the chiefs of services.

Staff members whose cases are to be discussed should be notified by letter one week in advance of the meeting.

Attendance at staff conferences should be limited to members of the hospital staff.

Training Competent Hospital Executives

That university courses in hospital administration will never be successful until trustees have adopted a broad general standard of organization and administration and have come to a fuller appreciation of the great responsibilities and the numerous duties devolving upon the administrative head of a hospital, is the belief of Sidney Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich.

"Hospital organization and administration must be standardized on much the same basis as banks and trust companies," Mr. Davis points out. "A further need for such standardization is that trustees and superintendents may speak a similar language. There is no greater service the American Hospital Association could undertake than the development of standards which boards of trustees, in communities large or small, could, with complete confidence, adopt. The training of competent hospital executives should be undertaken in conjunction with such a program.

"The superintendent should be the president of the board of trustees and as such the managing director of the institution. He should go into board meetings on the same sure footing as every other member. He should lay before the board statements of operation, questions of policy and matters of unusual interest or of large import to the community and the institution. He should lead in discussion, giving the board the benefit of his knowledge in hospital administration, that it may be fitted in with their individual knowledge of the matter under consideration, and a fair decision or policy arrived at. Then he should direct the carrying out of those policies unhampered by any interference."

Why the Dietary and Social Service Departments Should Cooperate

The major part of treatment in the hospital, outside of surgery, is furnished by the dietary and social service departments, Bertha M. Wood, E. Northfield, Mass., emphasizes in a paper on the relationship of the dietary department to the social service department. The dietary clinic is the wholesale food fact center, while the social service department is the retail end of the therapy, according to Miss Wood.

When a patient is referred to the social service department a prescription slip, containing personal information, should be sent to the department. Full information as to dietary treatment, and why he requires such a treatment, must be included in the diagnosis. A small reference book, setting forth facts on food values, chemical changes of foods and the application of food as a treatment, would be helpful to the social service workers, such cooperation between the two departments promoting more efficient service.

"Eating has been considered a social function," Miss Wood says. "When its direction emanates from a doctor's prescription, it becomes dietotherapy. His prescription with the treatment specified should be passed on to the dietary department which in turn should translate it into means and refer it to the social service department for the information of the social worker to whom the case has been assigned."

Abington Hospital Broadens Its Service to Humanity

By TILDEN, REGISTER & PEPPER

Architects, Philadelphia, and

S. S. GOLDWATER, M.D.

Consultant, New York City

THE recent building operations of the Abington Memorial Hospital, Abington, Pa., are not regarded as final. An understanding of the plan for the future development of the hospital is essential to a proper appreciation of the recent construction. It is assumed by the hospital that as the community grows additional hospital facilities will be required. The available hospital plot has fortunately made it possible to develop a plan for a hospital that may ultimately accommodate from 500 to 600 patients.

The increase in bed capacity required an expansion of many supporting services, including nursing. The ultimate plan provides a location for a massive extension to the nurses' home, to front on Horace Avenue. This will connect with the present nurses' home. For the present it was thought advantageous to place the additional

nurses in a wing of the administration building. This permitted the architects to develop the administration building on architectural lines, and the hospital has thus acquired a dignified main front on Old York Road. At present so much of the administration building will be used for offices as the present capacity of the hospital requires. Future adaptations can be made without difficulty.

The administration building, with the principal entrance to the hospital, is most conveniently placed. From it one may proceed either directly forward, into the main section of the hospital, to the right toward the maternity building or to the left toward the nurses' home. Distances are thus minimized and central control facilitated.

The maternity building follows the modern conception of a department of this character. It is practically a self-contained unit. Only the base-



Abington Memorial Hospital, Abington, Pa.

ment of this building is used in part for other purposes, namely, for the out-patient department, and as this department has a separate entrance the perfect isolation of the maternity division can be maintained. Within the maternity building there are accommodations for private, semiprivate and ward patients, each division having its own floor. The labor and delivery rooms are in the rear wing outside of the main body of the building, in a location where perfect privacy can be maintained.

On each floor, the nurses' station and chart room has been centrally located. Each floor has its nursery, with a fully equipped infants' bath adjoining. The nursery is not entered directly from the corridor but through an intervening lobby, which helps to maintain an equable nursery temperature.

An adequate reception hall has been provided for the out-patient department. This hall, on the ground floor, is entered from the north end of the building. For registration, record keeping and the social service work incidental to the admission of patients, two offices have been set aside adjoining the registration room, for social service workers. The pharmacy is conveniently placed. Separate rooms or suites are provided, respectively, for the eye department, for ear, nose and throat work, for surgery, dentistry, gynecology and urology. Suitable quarters are available also for the state tuberculosis clinic.

The out-patient department, with its separate entrance, occupies the entire ground or basement floor of the main section of the maternity building. Separated from this division is the ground floor of the labor and delivery room section. Here, for the purpose of meeting emergency needs, there is a self-contained isolation ward, completely equipped for every contingency, with accommodations for four patients in separate bedrooms.

The reconstructed administration building bears little resemblance to its predecessor. Approximately one half of this building is new; the remainder has been remodeled. The new section, which is to be utilized for the accommodation of an expanded nursing force, will provide for fifty pupil nurses and six graduates. For the latter, there are single rooms with connecting private baths. The nurses' quarters occupy the first, second and third floors of this building.

On the ground floor of this section there are

spacious accommodations for nonresident special nurses, including a large locker room, dressing rooms with toilets and showers adjoining, and a special nurses' rest room and dormitory intended for the use of nonresident nurses on twenty-four-hour duty. This floor of the expanded adminis-

tration building also provides accommodations for the women's auxiliary and for a central linen and sewing room, an office for the housekeeper and extensive quarters for the department of physiotherapy, the location of which, midway between the out-patient department and the hospital proper, makes access easy to both in and out-patients.

When the "new nurses' home" was planned in 1921, teaching and recreational facilities suitable for the student body of that day were incorporated in the plans. These accommodations could scarcely be expected to measure up to the new requirements and substantial changes have therefore been

made in the new nurses' home, especially on the ground floor, where the facilities for teaching have been extended and modernized. The new demonstration room or nursing laboratory will be found to have great practical value, while the adjoining classrooms, laboratories and instructors' offices are all essential to the functioning of the school.

A department of the hospital in which the public is always particularly interested is the children's department. The children's wards in a general hospital should be so placed that there need be no general traffic through the department. A children's ward requires individual observation rooms for newly admitted patients, in order to check as far as possible the spread of epidemic diseases, and the remainder of the ward should be subdivided so that the older children can be separated from infants, boys from girls and medical from surgical patients. There should be an unusually spacious diet kitchen for the preparation of milk formulae. Although the ward should be subdivided, visual control of the ward must be maintained by the nurse or nurses in charge. All these conditions have been met in the reconstructed third floor of the older portion of the administration building.

Thus far nothing has been said about the principal new buildings. These buildings of the hospital are protected from the Old York Road by the administration building and nurses' home and





they look out upon the spacious convalescent gardens that lie between the hospital buildings and Horace Avenue.

The character of the site and the nature of its development are singularly adapted to hospital needs. Privacy, protection from traffic noises, ample exposure to the sun and a pleasant view over the hospital's own private grounds, comprise a combination of advantages enjoyed by few hospitals. The heart of the entire scheme is the so-called operating pavilion, really a building devoted to diagnostic and therapeutic purposes, which adjoins the principal patients' building of the present plan, and which will eventually become the central point of a balanced plan with approximately equal numbers of patients and of clinical units on either side. The main connecting corridor of the hospital penetrates the middle of this building and is in direct line with the entrance lobby of the administration building, the route lying through the middle of the principal patients' building.

The ground floor of the operating pavilion is divided into two sections of approximately equal size. In the front there is the x-ray department, which is arranged for both x-ray examinations and treatment. There is waiting space here for stretcher cases as well as for ambulatory patients. For the chief radiologist there is a private office and adjoining this a viewing room and an

examination and rest room. For the technical work of the department five separate rooms are assigned, respectively, to radiography, fluoroscopy, foreign body work, superficial therapy and deep therapy. Dressing booths connect with all of these rooms. A dark room for the development of x-ray films is entered through the maze. Much thought has been given to the technical details of this department, which is regarded by radiologists as one of the best of the kind in the country.

The reception of newly admitted patients, especially emergency cases, is one of the most difficult and exacting of all hospital functions, and careful study has been given to this feature of the plan. The location chosen for the emergency and admitting department, namely, the ground floor of the operating pavilion, has many advantages: (1) In the future this will be the central building of the entire hospital group, equally distant from all clinical departments and not too remote from any; (2) it immediately adjoins the x-ray department, important for diagnostic purposes in accident cases; (3) it is directly below the central laboratories of the hospital, indispensable to many forms of diagnosis; (4) it is in the same building with the operating rooms, to which emergency cases requiring immediate major operations can be transported without loss of time.

Within the department itself, there are two

emergency treatment rooms adjoining the vestibule and ambulance entrance. There are waiting rooms and history rooms for the accommodation of patients and their friends. The department includes four separate two-bed wards, with connecting toilets, and is completely equipped as a nursing unit, with its own sterilizing room, utility room and workroom, linen and supply closets and ward kitchen.

The southerly half of the first floor contains quarters for interns and residents. On the northerly half of this floor are the completely equipped laboratories of the hospital, including separate departments for bacteriology and immunology, serology, chemistry, tissue pathology, clinical pathology and metabolism. There is a work and preparation room for the use of all the laboratories, an office for the director, a waiting room and two examining rooms for patients calling for laboratory tests.

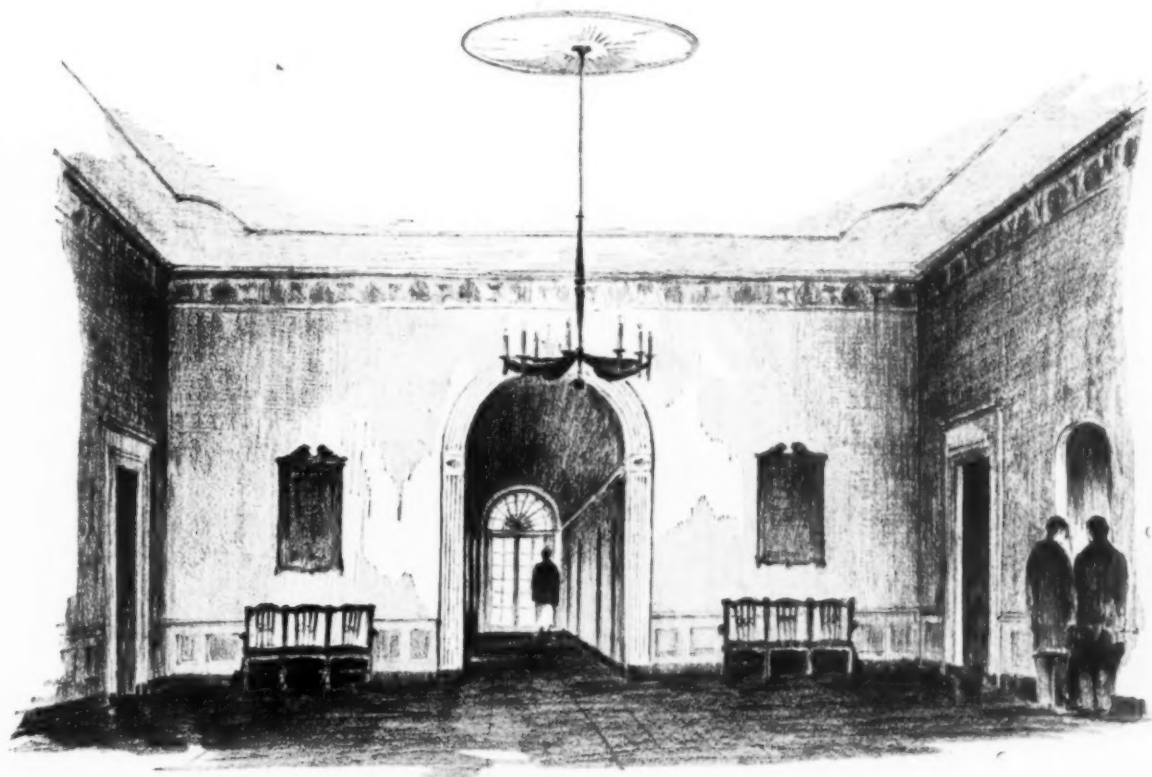
Like the x-ray department below, this department is a complete, self-contained unit. An important advantage has been gained by placing this building in a location where it may be indefinitely expanded. No matter what the demand may be on the diagnostic and therapeutic departments of the Abington Memorial Hospital in the future, there will be no difficulty about adapting the building to the future needs.

The second floor of the operating building contains the operating rooms proper, from which the

building derives its name. Here, north of the main corridor, are the operating rooms proper, with connecting sterilizing, anesthesia and scrub-up rooms. The major operating rooms are 17 by 21 feet, and have abundant north light. The grouping of the auxiliary rooms is such that an anesthesia room, a sterilizing room and a scrub-up room open directly into each of the four principal operating rooms.

South of the main corridor is the central sterilizing and dressing room for the preparation of surgical supplies for the operating rooms, and indeed for the entire hospital. The large dressing sterilizers have been built in for heat control. The nurses' workroom has three windows and cross ventilation. An office for the supervising nurse adjoins the nurses' workroom. The locker and dressing room for the staff is conveniently located and of ample size.

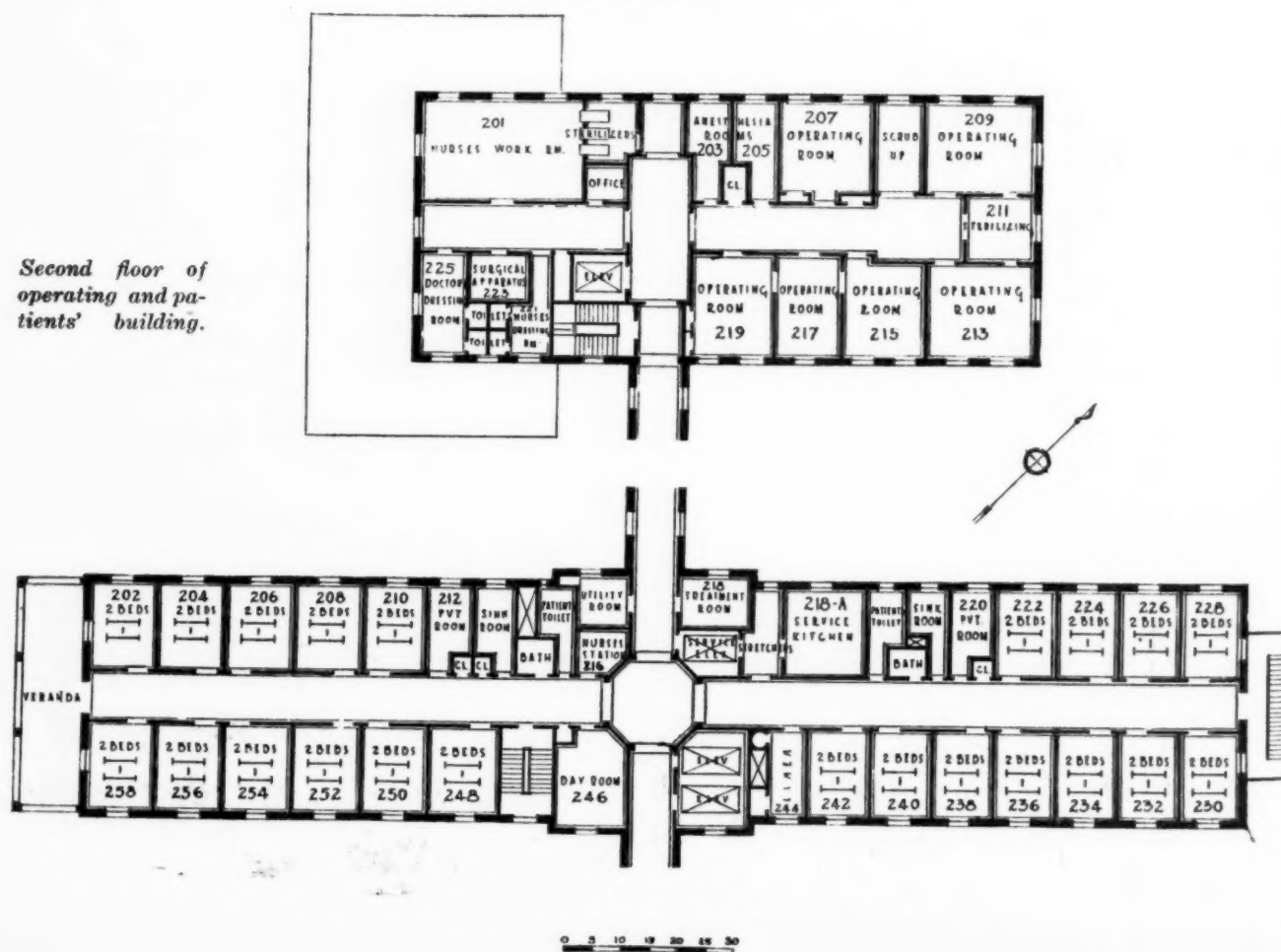
The largest single building in the present building program is the so-called patients' building, which, however, is a great deal more than the name implies, since this building includes the general supply rooms of the hospital, the main kitchen, dining rooms for the entire working organization, as well as accommodations for ward and private patients. The basement is devoted in the main to classified storage. On the ground floor there is a rear entrance for receiving supplies. From this point supplies intended for the general storage room in the basement are dis-



First floor of operating and patients' building.



Second floor of operating and patients' building.



patched by elevator to their destination. The principal supplies that are received daily at the hospital, are, however, those intended for immediate consumption in the kitchen, and the kitchen storage and workrooms immediately adjoin the receiving lobby.

The ground floor of this building has been extended in order to provide sufficient space for the main kitchen and for its accessory service rooms for the special diet kitchen. The service elevator and food dumb-waiter open directly off the main kitchen. The southerly half of the ground or kitchen floor has been arranged for dining room

eleven-bed ward being on one side of the nurses' station and the smaller wards of four, two and one beds, respectively, on the opposite side. Altogether, each of the two ward floors is intended for the accommodation of forty patients, divided into two separately controlled groups.

The arrangement of the wards is such that the penetration of this floor by the central corridor, which leads from the administration building to the operating building, will interfere in no way with the quiet and isolation of the wards. A reception room for visitors opens off the main or connecting corridor. The elevators likewise face



Ground floor of
operating and
patients' building.

purposes, with a central serving room. Separate dining rooms have been provided for pupil nurses, graduate nurses, administrative officers, medical staff and clerical force. The dining rooms for domestic help are opposite the kitchen and have no contact with the dining rooms just enumerated.

The first and second floors of the principal patients' building accommodate ward patients. The largest single ward accommodates only eleven beds and may be divided into individual cubicles. There are two of these eleven-bed wards at the extremities of the buildings. Each is 21 feet wide and 42 feet long; each has seven windows, and is exposed on three sides, thus ensuring cross ventilation. Each ward section has its nurses' station and workroom centrally located, the

the connecting corridor and are so arranged that elevator noises will not reach any patient's room or bed. Also opening off the main corridor, are a patients' examining and dressing room and a nurses' workroom with complete sterilizing equipment. A telephone booth for visitors' use is another detail of the central section, near the visitors' room. A veranda, 11 feet wide and 40 feet long, stretches across the southerly extremity of the building. In a corresponding position, at the opposite end of the building is a fire tower.

A service kitchen has been centrally located on each floor. This is entered through a side corridor and it is hoped in this way to confine kitchen noises and kitchen odors. There is a large central linen and supply room for the use of the entire

floor. Separate toilet and bathing facilities are provided for each ward group. Running water has been installed in the larger wards, and in a convenient central location in the corridor adjoining the small wards.

The third and fourth floors are devoted entirely to private rooms. The passenger elevators open into a lobby 12 by 24 feet. Opposite the elevators is a small reception room. At one end of the lobby is the nurses' station and charting room. Opening off the nurses' station are the central utility and sterilizing room and the nurses' retiring room. From the nurses' station, visitors and staff members entering the floor can be immediately observed and the necessary service rendered.

Grouped about the central or tower section are certain other features common to the entire floor. One of the most important is the service kitchen, which, like the service kitchen on the ward floors below, is entered indirectly through a side corridor, planned for noise and odor retention. On one side of this service corridor is the service kitchen, on the other is the flower room. Directly opposite are the linen room, clothes chute and janitors' closet. Separate sink and toilet rooms are provided for each patients' section.

View From Roof Is Inspiring

Although the building is considerably more than 200 feet long, it is broken up into smaller units so that the longest unbroken corridor is only 88 feet long. The width of the corridor is 8 feet. In the southerly corridor there are twelve patients' rooms; four of these are rooms de luxe, 11 feet 5 inches in width and 17 feet in depth, with individual private baths. The smallest rooms in this section are a little over 10 feet in width and 16 feet in length. Each room has its own washbasin and a built-in closet. At the opposite end of the building, opening off a second 88-foot corridor, there are eleven rooms; three of these are de luxe rooms with private baths; other rooms, with wash bowls and closets, range in size from 9 feet 6 inches by 16 feet to 11 feet by 17 feet.

An important feature of the patients' building is the roof, the view from which is inspiring. The roof development includes a large enclosed solarium, a covered or semiprotected roof garden and a considerable area of tiled open roof for sun baths.

The remaining features of the hospital are concerned for the most part with domestic administration. The boiler house is new and may be indefinitely expanded. The new help's dormitory building will accommodate a considerable proportion of the workers needed for the domestic service of the hospital. Besides the double bedrooms

for the help, the dormitory building includes separate living rooms for men and women servants.

In planning the lighting, signal and ventilating systems of the hospital, and its mechanical equipment, the experience of the entire country has been drawn upon and an effort has been made to install modern and serviceable equipment.

Acknowledgments are due to John L. Burgan, superintendent of the hospital, for his constant cooperation and for many useful suggestions, and to members of the hospital staff for suggestions concerning the arrangement and equipment of their respective departments.

New York Hospitals Aid in Care of 22,000 Chronically Ill Persons

Close to 22,000 cases of chronically ill men, women and children in the care of medical or welfare societies have already been recorded in a census of all chronically ill persons in New York City, who are receiving care from social agencies or institutions, according to Dr. Neva R. Deardorff, director, research bureau, Welfare Council.

The Welfare Council's research bureau sought information from 235 agencies and secured schedules from 206. From these it collected a total of 23,613 schedules. When the duplicates were removed, a net total of schedules for 21,732 persons were accepted for analysis.

Of the total, 6,749 chronically ill persons were reported by the public health nursing organizations, 5,326 by public institutions, 2,829 by private homes for the aged, 2,765 by private hospitals, 1,689 by family service societies, 901 by agencies supervising cardiac children, 866 by convalescent homes, 536 by sheltered workshops—where persons with handicaps of illness may work under special conditions and subsidies—and seventy-one by visiting doctor services.

On each schedule were some forty-eight items of information. Thus a total of something over a million items of information have been recorded and edited and are to be tabulated for this study.

The analysis of this material will view it from two points, Doctor Deardorff points out. First, will be a description of the problem of chronic illness as it presents itself to agencies often dealing with these patients from some other point of view than that of caring for their illness. Homes for the aged, for instance, are usually not equipped as hospitals. Second, there will be analysis of this group of people from the broad community point of view. These 22,000 persons break up into three main classes that require care from different points of view.

A rounded program for the care of chronically ill persons covers services by chronic disease hospitals, custodial institutions, homes for the aged, general hospitals, visiting nursing associations, social service in clinics and dispensaries, outdoor medical service, family welfare and relief, private nursing or boarding homes, sheltered workshops and special committees.

Dr. Ernst P. Boas, former superintendent of Montefiore Hospital, was chairman of the Welfare Council's special committee to plan and carry through this study. Doctor Boas is recognized as an authority in the study of care of chronic patients.

Credit Policies That Reduce Losses in the Small Hospital

By RALPH M. HUESTON

Superintendent, Silver Cross Hospital, Joliet, Ill.

ONE of the chief assets of the average community hospital in its early years is the enthusiasm of the community in helping to solve the financial and other problems of the hospital. But as time goes on this enthusiasm decreases, until a day comes when the hospital is expected, as the saying is, "to go it alone." Fortunately, some hospitals reach the point where they can accomplish this, but the vast majority of hospitals, operated not for profit, constitute financial problems for the communities they serve.

Almost every hospital administrator and most boards of trustees can tell the "whys" and "wherefores" of this unfortunate financial condition, but, for reasons hard to explain, the general public has not accepted their explanations. This fact has made necessary a change of program in handling the finances of hospitals.

It seems, however, that most boards of trustees have given more attention to endowment programs, tag days and linen showers than they have given to patients' accounts. As probably more than 75 per cent of all hospital receipts come from patients' accounts, it is almost imperative that a sound credit policy be followed. Especially is this true if the hospital has no endowment or has only a small endowment. The ever increasing demand for more and better service makes it necessary that money be available to provide this service. It is therefore the administrator's responsibility to give serious attention to the collection of patients' accounts.

Team Work Is Needed

Close cooperation of all departments is necessary if the problem of the proper handling of patients' accounts is to be solved. The bookkeeping department alone cannot do it. Every person, from the student nurse up, who holds a responsible position and who comes in contact with the patient, has a definite part to play in assisting the hospital in the collection of accounts. Detailed instructions on the collection policies of the hospital should be given regularly, so as to keep the personnel posted on what is expected of them.

From the standpoint of dollars and cents there

are only two classes of patients admitted to the hospital—those that pay and those that do not pay. Of those that do not pay there are two groups, "known charity" and what is courteously called "doubtful accounts." We shall consider here only the two groups of the class that do not pay.

The first consideration in the question of credits in hospitals operated not for profit is the policy for handling charity patients. This policy is generally established by the governing body of the hospital. Some boards of trustees have decided that it is fair to confine the charity service of the hospital to those who reside within the territory served by the hospital. Usually this is considered to mean the county in which the hospital is located. This policy is adopted on the assumption that the hospital is obligated in its charity work only to the community in the territory that is responsible for the hospital.

Who Is Responsible for Pauper Cases?

The second consideration is the question of the responsibility of the town or township and the county for the pauper cases that do not come under the hospital's charity list. Too often this responsibility is disputed and is finally settled at the expense of the hospital. Administrators as well as boards of trustees should use their efforts in establishing connections with city commissioners, county supervisors, the city physician, the county physician or whatever type of governing body is interested in the hospital. The hospital should not be forced, as it too often is, to assume the responsibility for the cost of hospital services for the town and county charges. There is no reason why a fair cooperative policy for town, county and hospital cannot be worked out, as it is in Knox County, Illinois. Here the minimum amount of disputes arise and a satisfactory settlement, at least as far as the hospital is concerned, is always made.

The third consideration has to do with patients admitted to the hospital who are expected to pay but for various reasons do not pay. The question of keeping at a minimum the ever increasing doubtful account list is the special problem of

each individual hospital. Policies that work in one locality may fail completely in another. However, policies can be established that with the use of good judgment will curtail materially the loss from doubtful accounts.

It is not always well to try to enforce the payment-in-advance policy but it is always good business to have such a policy. In states where the county is responsible for the hospital expenses of nonresidents (if the nonresident cannot meet the demand for payment in advance) the county physician can be notified and the county is obligated to take care of the patient. Often the suggestion of such a procedure will bring payment when otherwise the patient would not pay. The pressure of the payment-in-advance policy will often result in the payment of accounts that otherwise would go unpaid.

Weekly Payment Policy Advantageous

The policy of requiring payment weekly as service is rendered often helps in determining the ability of the patients to pay. In smaller communities the physician in charge of the patient generally makes the arrangements for the patient. The physician does not always know the ability of the patient to pay, and often accommodations are reserved that the patient cannot afford. While the physician will gladly assist the hospital with all the information at hand, he is usually too busy with his own responsibilities to give much help in establishing proper credits for his patients. The burden of responsibility is on the administrator. It is he who must pass on the credit of the patient. With the weekly payment policy the patient is familiarized with the cost of service. If cheap accommodations are desired they can be arranged for. If the patient does not pay the first week's statement and the administrator considers it advisable, the patient can be requested to take cheaper accommodations. The weekly statement also helps to avoid price disputes.

Hospitals should try to avoid losses arising from disputes regarding responsibility for the account. In accident cases particularly, there are times when one party will consider a second party responsible for the payment of the hospital expenses. It is not uncommon for claims to be held pending for months. Should the hospital be expected to depend on settlement of claims for its money? No. The patient should be required to pay for the services he receives. Any third party responsibility should be independent of the hospital except when definite arrangements in the matter are made at the time the patient is admitted to the hospital.

The community hospital operated not for profit

usually definitely defines the type of cases that it will accept and also definitely defines the type of cases it will not accept. This done, the hospital is obligated by its responsibility to the community to accept all cases that come under the heading of acceptable cases, regardless of the ability of the patient to pay. Ordinarily the patient is permitted to select his room or bed accommodation. However, it is advisable for the board of trustees to delegate to the administrator jurisdiction over the accommodations of the hospital. The staff, being familiar with this ruling, cannot question the authority in the transfer of a patient from a private room to ward accommodations because of the inability of the patient to pay for the more expensive accommodations.

Not all patients that don't pay, can't pay. Some of the patients that can pay but won't, except when forced to, will pay rather than be transferred from the private room to ward accommodations. The administrator may offend one patient or several patients, and probably a doctor or two will voice an opinion, but when the policy is known and the administrator exercises good business judgment, the results will prove to the advantage of the hospital.

Emergency cases should be cared for regardless of the patient's ability to pay. Except in cases of emergency, anyone applying for service such as laboratory, x-ray, operating room, cast room, dressing room, dispensary, in fact, any outpatient service, that is, when the patient does not take bed accommodations, the collection policy should be cash in advance. Sometimes it is necessary to give credit even with a cash in advance policy. In one hospital, the changing of the policy of cash following service to cash in advance resulted in a reduction of the doubtful account list to less than one-third of what it was before.

Good Follow-up System Necessary

A poor collection policy will result in many accounts not being paid that would have been paid under a more firm policy. Sometimes administrators are inclined to be too sympathetic in enforcing collection policies. The time to get the money is while the patient is in the hospital. The valuation of accounts unpaid when the patient leaves the hospital varies considerably throughout the country, but estimates from several hospitals of the type about which this article is written indicate that sixty-six and two-thirds cents on the dollar is all the account is worth. With the services of the hospital being offered to the patient at an average of about cost, or, as in many cases, at less than cost, it is essential that every effort be made to collect for services rendered.

Patients that do not pay their accounts in full while they are in the hospital should be required to arrange a definite schedule for payment at the time they leave the hospital. Some hospitals have found it much to their advantage to require the signing of a note for the unpaid balance of the account. The note, while not always collectable, does serve as a signed acknowledgment of the obligation, and it prevents disputes of the responsibility for the account arising at a future date. A short term note is usually considered better than a long term note. A short term note stimulates prompt payment. As the note becomes due, if it must be renewed, as is often the case, the one signing the note can be encouraged to reduce the note, at least, each time the note is renewed.

A good system of follow-up on unpaid accounts is necessary. Merely to mail out statements is not enough. Too often these mailed statements are ignored. Personal solicitation is a tried policy that has proved well worth the time and effort. As the installment plan of paying is usually handled by the women members of the family, a woman collector can more often get attention in the home. Most men seem to arouse antagonism, while the average woman collector can make contacts in the home that result in payment on accounts. The cost to the hospital is less, and the result better. As an incentive to work, the collector can be given a small commission on all collections. One hospital pays a salary of \$100 a month and 2 per cent on all collections less than one year old, and 10 per cent on all collections over one year old. Under the commission policy the collector, when it is found large payments on account cannot be made, will encourage small payments. Most of the well intentioned patients whose financial circumstances require time payments will welcome the regular calls of the collector. The collector should be bonded and should report to the hospital the results of the previous day's work each morning, but otherwise the collector should be given a free hand to carry on the work to the best advantage.

Collector Submits Monthly Report

Working directly under the supervision of the bookkeeper, the collector should have a private file of the accounts in charge. The collector on the first of each month should give the administrator detailed information regarding accounts of all patients leaving the hospital who have not paid in full. This should include the name of the patient, the name of the attending physician, the rate charged for bed accommodation, the type of illness and the unpaid balance of the account. A summary, showing the total number of private

room patients, the number of ward patients and similar statistics, should accompany the report.

A careful check, month by month, particularly of private room accounts, will, in time, help to form credit policies that will materially reduce the loss from doubtful accounts. For the accounts of patients who cannot pay and who take the cheapest ward accommodations, very little can be done, but it is the duty of the administrator to prevent as many patients as possible from taking private room accommodations for which they cannot pay.

A committee composed of the chairman of the finance committee of the board of trustees, the administrator of the hospital, the administrator's bookkeeper and the collector should meet at regular intervals for the purpose of making disposition of all accounts that cannot be collected through the hospital's collection policies.

Georgia Court Holds Hospital Card Inadmissible as Evidence

A hospital card was ruled inadmissible as evidence in a case wherein an insurance company was attempting to avoid paying the amount of the policy to the beneficiary on the ground that the insured had made false and fraudulent misrepresentations to the company.

The admission of the card was objected to because it was not shown to be the original record and because it was hearsay, according to a review of the case in the *Journal of the American Medical Association*. The witness who produced the card that was supposed to be a history of the case admitted that he did not know who made out the card; that it was simply a paper found in the hospital and that another physician at the hospital had handed him the card but did not say whether it was or was not an original card.

A judgment in favor of the beneficiary was returned by the lower court, and when appealed to the court of appeals it was sustained.

Pensioning Nurses in Scotland

A federated superannuation scheme for providing pensions for nurses has been initiated by Sir Edward Penton in Scotland, under the auspices of the Scottish regional committee, British Hospitals' Association, the *Hospital, Medical and Nursing World* reports.

The scheme resembles the pension plan of universities in that it is contributory in character, the hospital taking out insurance for its individual employees. The annual payments are based on a percentage of salary and emoluments, to be paid partly by the employer and partly by the employee. The total contribution is 15 per cent of the salary, the hospital paying 10 per cent and the individual 5 per cent.

The policy is valid if the individual goes to another institution within the scheme, or, within certain limits, if she leaves the service entirely. The limit of service has been fixed at ten years in the case of an officer and five years in the case of a nurse.

Coping With Overweight by Means of Diet Therapy

By LULU G. GRAVES

Consultant, New York City

OVERWEIGHT and methods of reducing have become questions of importance in professional circles, largely due, no doubt, to the fact that they have been given so much attention in nonprofessional circles. Whether this attention may be attributed to more interest and intelligence in matters pertaining to health, to fashion's degree or to other causes, the fact remains that discussion of these subjects has been widespread.

The interest of the nonprofessional has probably been enhanced by articles in the public press, by radio talks and by advertising. The effects of these discussions have been both good and evil. Among the good results are an increased knowledge of the serious consequences and complications ascribed to overeating and overweight and an extensive education on food values.

A number of medical men and dietitians who are doing notable work with metabolic diseases, and a few nutrition experts were asked by letter for an expression of their opinion upon pertinent factors relating to this subject. The comprehensiveness and cordiality of the replies to the letter are eloquent testimony of the prominent place that the subjects of overweight and diet occupy in medical therapeutics. Approximately a hundred replies were received. In giving a summary of these replies and quoting from a few, we present representative points in the method of meeting the problem of overweight due to improper diet. Practically all replies considered overeating as synonymous with obesity.

Serious Results of Overeating

The first question read: What do you consider some of the most serious results that may be attributed to overeating?

The answers were classified as follows: general debility and diminished life expectancy, 51 per cent; hypertension, 47 per cent; diabetes, 44 per cent; heart disease, 41 per cent; organic disturbances, 31 per cent; nephritis, 28 per cent; liver disturbances, 16 per cent; orthopedic difficulties, 7 per cent; appearance marred, 7 per cent; gout, 4 per cent; constipation, 4 per cent; cerebral hemorrhage, 1 per cent; varicose veins, 1 per cent.

On the question of diet restriction, 29 per cent

approved of restricting fats, starches and sugars to an equal extent; 40 per cent favored restricting fats more than sugars and starches; 68 per cent thought sugars should be restricted more than starches; none thought that starches should be restricted more than sugars; 16 per cent were equally divided. Concerning meat restrictions, 18 per cent would restrict fat meats only, while 26 per cent would restrict meat generally.

The question was asked: Have you found a diet of coarse foods to be harmful in general? Sixty-five per cent answered "No," to this question; 15 per cent answered "Yes."

Starvation Diet Is Unnecessary

On the question of artificial means of allaying hunger opinions approving and disapproving of these were about equally divided. Miscellaneous means mentioned include serving five or six small meals instead of three; distracting the patient's mind by outside interests; serving 3 to 5 per cent vegetables; supplying crackers, apples and other light food between meals; encouraging the use of cigarettes or chewing gum. The use of drugs and reducing tablets and the habit of going without meals indiscriminately were universally condemned.

The great number of diseased conditions mentioned as directly attributable to overweight was noticeable, as were also numerous references to the fact that the life expectancy of an overweight person is not so great as that of a normal weight individual. This was almost always followed by a reference to the attitude of life insurance companies. A few references were made to the effect of overweight upon the personal appearance.

It was the consensus of opinion that a diet to be effective is not necessarily a starvation diet. It must conform to the fundamental principles of nutrition if serious damage to health is to be avoided. A generous use of liquids, such as broth, tea, coffee, orange juice and, in a majority of cases, water should be encouraged, the replies indicated.

Quotations from some of the replies follow:

Dr. W. D. Sansum, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

"I place my patients on very low fat diets and

restrict both starches and sugars. I use approximately 130 grams carbohydrate, 60 grams protein and in the neighborhood of 30 grams fat. A reducing diet must contain ample carbohydrate to bring about the combustion of the fat lost as weight without producing the acetone type of acidosis. I serve carbohydrate in the form of low percentage fruits and vegetables. I do not restrict meats unless the patients have high blood pressure in which case I place them on fruit, vegetable and milk products diets.

"My patients as a rule are surprisingly free from hunger. Large servings of low percentage fruits and vegetables seem to satisfy them. I have no objection to cigarette smoking, to the drinking of water, tea or coffee or to the chewing of gum."

Mary F. Henry, Professor of Nutrition, Cornell University, Ithaca, N. Y.

"I approach the problem from an angle different from that of primary emphasis on reduction of these foodstuffs. That is, I set the calorie allowance at, say from 1,600 to 1,800 calories, more or less, depending on the person's weight and his occupation. I then start to build up this number of calories with the essential foods, by which I mean those foods that must go into a diet to safeguard vitamins and ash materials.

"These foods include not less than a cup and a half or two cups of milk, primarily to safeguard the calcium requirement; an egg; fruit and vegetables, with emphasis on those highest in iron and vitamins. I give a serving of potato because of its high food value, and also a serving of meat for its iron and flavor. These foods provide about 900 calories. I add then the minimum amount of fat to make these foods palatable.

"Since there is still danger of deficiency of ash and vitamins to make the allowance of calories, the additional foods must still be of high value for materials other than calories. This probably means that cereal or bread from the entire grain should be included with fat again to make them palatable."

Dr. V. E. Levine, Professor of Biological Chemistry and Nutrition, The Creighton University, Omaha, Neb.

"Since overweight is essentially an index of wrong living, it is liable to hit any organ or to cause any degenerative disease. Overweight produces also many distinct minor disadvantages. It induces postural and static difficulties on account of excess weight of the trunk. The leg muscles may feel weak. Walking easily produces fatigue, and flat foot is very common. Backache is not an infrequent complaint. Hernia is another condition

that is liable to occur when an overweight condition exists. The muscles of the body including the muscles of the abdominal wall are flabby. The stretching of the abdominal wall causes hernia. It also causes sagging of the abdominal organs. In the middle aged business man this is not so much a sign of financial prosperity as it is a sign of physical bankruptcy.

"Overweight is also a mar to beauty. The human form is a beautiful piece of architecture. The angles and curves of the body are designed to give flexibility and expression. An excess of fat destroys grace and delicacy. A fat face has a monotonous uniformity. And the little niches, crevices and curves—the high lights of the artist—these little anatomical devices that give individuality to the face, all disappear before the onrush of avoirdupois. The theatrical producer does not choose a plump actress for the leading lady if he is in need of intensive acting that requires the delineation of various moods and the outpouring of the greatest depths of pleasure or grief the human soul is capable of.

"It has been proved experimentally that a diet low in calcium and phosphorus induces overweight in animals. This overweight becomes more prominent as the animals advance in age. Clinically it is not an unusual observation to find anemic patients overweight. An individual suffering from pernicious anemia is usually plump. The intern in the hospital in taking his history usually designates him as 'well nourished.' Whenever, I am forced to cut out fats altogether I insist on egg yolk, herring, spinach and raw carrots. The first two foods are rich in vitamin A and D, and the last two in vitamin A."

Dr. Solomon Strouse, Chicago

"Regarding diets, it seems to me that it is almost entirely a question of total horizontal reduction. By this I mean that a person should eat starches, fats and meats, but the starches and fats are reduced more than the proteins. Of course, there are individuals in whom an analysis of their food habits shows a marked overindulgence in some particular food, such as bread and butter, candies or even French dressing. In such individuals it is obviously wise simply to remove the excess before prescribing rigid dietary restrictions."

Dr. Harry Gauss, Denver, Colo.

"A person whose normal weight is 150 pounds and who weighs 180 pounds is carrying 20 per cent increased tissue by weight, the kidneys must excrete waste matter from 20 per cent increased tissue, the liver and pancreas must function for the same increase of tissue and so all the viscera are taxed by the increased burden. It is true that

the viscera of the body possess a margin of safety and are capable of increased labors, but nevertheless they are not functioning under optimum conditions, and this extra strain carried on for a number of years must result in their inevitably breaking down before their life expectancy.

"Since the dietetic management of obesity aims at the removal of body fat which is the reserve energy depot of the body, it appears logical in the first place to remove the fat from the diet, and in the second place to reduce the caloric intake to less than a maintenance diet. As a result the body is forced to call forth some of its reserve energy which is body fat. In the third place the nitrogen equilibrium must be maintained and it is necessary also to supply the required amounts of salts, vitamins and roughage."

Gertrude T. Spitz, Dietitian

"At the North End diet kitchen of the out-patient department of the Massachusetts General Hospital, we saw more than 1,250 new patients in 1927. Of those whose conditions might have been attributed to overeating were the mild diabetic (the obese type), the gall bladder cases, those with simple hypertension and those with orthopedic difficulties, chiefly flat foot and back strain. In addition to these are the obese persons who come in complaining of vague symptoms and who are referred for preventive measures. Only a few come in for diet just because they are too fat and want to get thin.

"I approve of restricting sugars far more than starches or fat, and fats more than starches. The amount of fat restriction depends on the previous diet of the patient and the age. Meats are not restricted unless there are contra-indications to their use. An effort is made to see that each patient gets sufficient protein. One of the crying evils of unsupervised reduction diets is restriction of protein below body needs. We have found no harmful effects from our diet. We do not recommend additional bran for roughage and the salads and vegetables recommended appear harmless."

*Dr. John F. Bresnahan, Medical Director,
St. Mark's Hospital, New York*

"I think heredity has not been sufficiently stressed as a weight factor. This question has nothing to do with the classic battleground of environment *versus* heredity, because most, if not all scientists would be willing to grant that structure—although perhaps structure alone is heritable—is inherited. It seems to me that this as a weight factor should be recognized, because certain structures are designed to carry certain weights, a point that I have never seen attention called to with regard to the human body."

Helva Nichols Church, Dietitian

"We had an interesting overweight clinic at Cornell. Doctor Spencer, the physician in charge of this clinic, has been carrying on research work with Doctor DuBois on overweight patients.

"In taking histories of the previous dietary habits of patients I was appalled by the erroneous ideas they had as to methods of reduction. There was also another group, not concerned about personal appearance, who were consuming what seemed an impossible amount of food.

"I believe in restricting the diet in calories below body requirement sufficiently to cause weight to be lost at a safe rate, but I think it is important to maintain the proper ratio between carbohydrate and fat and to supply sufficient minerals and vitamins. I do not restrict meats. I have never entirely eliminated artificial means of allaying hunger, for it often helps the morale of patients. However artificial means should be allowed only in moderation.

"I am very much in favor of directed exercises as an aid in reduction and in keeping the body in good tone."

Dr. George Baehr, New York City

"The most serious results of overeating can be ascribed to the effect of obesity upon the development of metabolic disturbances such as diabetes and upon the early appearance of vascular disease such as those of the heart and of the blood vessels. Although the increased tendency of obese individuals to develop diabetes is now common knowledge, it is not generally realized how important a predisposing cause this may be in the development of arteriosclerosis of the aorta and larger vessels. I do not think, however, that it increases the tendency to vascular disease of the finer arterioles.

"In controlling obesity, it is most important to teach individuals correct habits of eating and if necessary to overcorrect some of their dietetic errors. The appetite can be satisfied by a high protein diet to which are added bulky vegetable foods that are low in carbohydrate.

"I seldom find any necessity for employing artificial means of allaying hunger. Of course, in some obese individuals, the malady is a character defect, an evidence of lack of self-control and this is the group who follow the faddists for brief periods; but they seldom remain loyal to any system of fat reduction. I think it would be better to leave this type of person to the faddists and restrict our efforts to helping those who can appreciate the importance of adhering to dietary restrictions based upon accepted scientific principles."

Where the Junior College and the Nursing School Cooperate

By

C. VAN SWALENBURG, M.D.

Medical Director, Riverside Community Hospital,
Riverside, Calif.

CALIFORNIA has gone a long way in establishing the junior college as a definite section of its educational system and it is becoming more popular as its advantages are being demonstrated.

The college takes high-school graduates and allows them for the first two years of college work to study at home, under the supervision and companionship of their families. Their diplomas admit them not only to the junior class in the state university, which is a part of the state

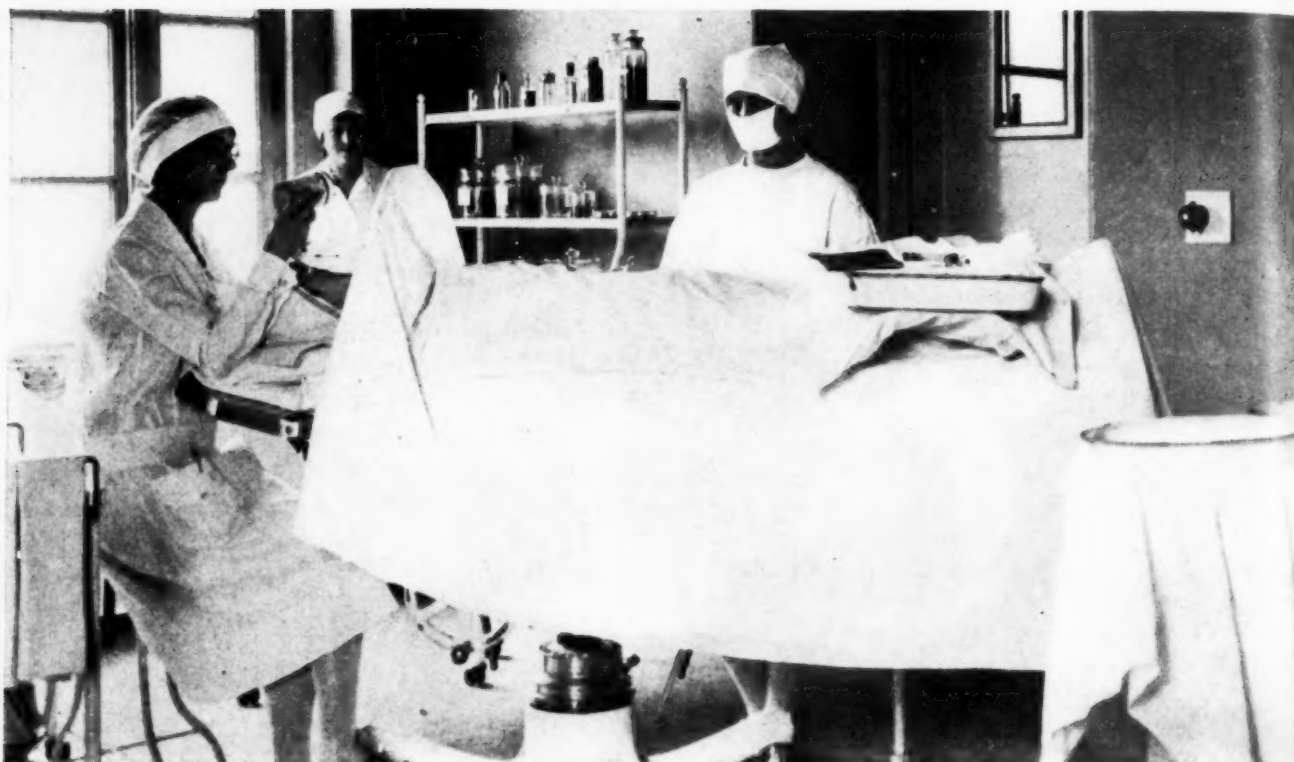
educational system, but also admit them as juniors in practically any other college or university the pupils may choose to attend.

We believe that the junior college is admirably adapted for amalgamation with the school of nursing and this arrangement is being carried out by several hospitals in California. Riverside Community Hospital, Riverside, however, is the only one that has established a cooperative course. Riverside Hospital was one of the first to establish a junior college (1916) and was the first to adopt the plan of cooperative education (1922). It has established a number of cooperative courses, which means that the student spends alternately six weeks in college and six weeks at some active occupation. There are courses in commerce, engineering, architecture and nursing. This means that if the student nurse is to receive two years' college credits she must continue the course three years.

Cooperative students are paid for their work during the six weeks they are out of college and of course the vacations can also be spent in work. This offers an opportunity for the student practically to pay his way. However, this possibility is



*The modern nurse is
skillful, intelligent and
essentially human.*



The ties between the hospital and junior college offer chances to combine practical experience with the theory gained through college studies.

always considered incidental and is kept in the background. The real appeal is to the bright student, practical enough to see the advantage of mixing preaching with practice, the didactic with the practical, the text with the laboratory.

Riverside Community Hospital is fortunately situated, about three blocks from the junior college, with the nurses' home four blocks from the hospital and seven blocks from the college. Our new hospital was opened in the spring of 1925 about the time the affiliation with the college was

established, and, up to date, this arrangement has been most satisfactory. Nurses, nursing instructors and hospital administrators are accepting the nurse as a professional woman, and the time has come when the school of nursing must be a real school. This is of especial interest in view of the arguments frequently heard in favor of having schools of nursing as entirely separate institutions, that is, separate from the hospital, using the hospital only as a laboratory.

No longer is the nurse considered a servant.



Riverside Community Hospital, Riverside, Calif.

The physician must meet her as a coordinating worker in a cooperating profession. Service will always be with us, but it must be dignified, skillful service, with refinement and sympathetic understanding—the same sort of service the physician renders. The attitude of the doctor, the nurse and the hospital is, "Are you in trouble, we are here to serve you together. What can we do for you?"

The following is an outline of the curriculum:

	Units
Bacteriology	3
Chemistry (Inorganic)	6
Chemistry (Organic)	4½
Chemistry (Physiological)	4½
Elective	7
English	9
Foods	6
History of Nursing	1½
Human Body	9
Hygiene	1½
Orientation	6
Physical Education	4½
Psychology (General)	4½
Psychology (Abnormal)	3½
Public Sanitation	1½
Total	72

In addition to the junior college courses listed above, numerous strictly nursing subjects are taught at the hospital by special instructors. For this work the college allows twenty-four units.

At the end of three years the student receives a diploma of graduation from the Riverside School of Nursing, which entitles her to the regular examination for California registration (R.N.), and a certificate of graduation from the junior college, admitting her to junior standing in the University of California.

The outstanding feature of the course is the six weeks' alternating between college and hospital. Our hospital thus becomes a practical laboratory in which to correlate the didactic studies taken in the college and the nursing training. Our students are much pleased with the change. Six weeks in college makes them eager to spend the next six weeks in the manual duties of the hospital. There seems to be more or less brain rest in coming to the hospital, and likewise in going back to college after they have had the physical duties of the work at the hospital. The criticism has been offered that it takes several days for them to readjust themselves after making this transfer, but we find that the students slip into their alternate places simply, automatically and without a break, in fact with new enthusiasm.

The hospital, of course, teaches the practical

procedures and their application. We find that the scheme has brought to the school a higher grade of applicants than we had before. It attracts the young woman with a broad outlook upon life. She is interested in right principles of living. She appreciates the tremendous importance of service. It appeals less to the one who is frivolous. Most of our girls are thoroughly interested in their work and look upon the care of their patients as an opportunity to do constructive work.

Up to this time our students have been housed in the nurses' home for the entire three years, except during the three months' affiliation with the Children's Hospital, Los Angeles, six weeks



The nurses are well drilled in minor hospital duties.

spent at the Metabolic Clinic, La Jolla, and nine weeks' vacation. A few have lived in their own homes instead of at the nurses' home. We expect that in time most of our students will live in their own homes, especially those who reside in the city. As we now have and probably always will have a number of students from surrounding cities and towns and even from out of the state, we shall need some form of dormitory. At present we are paying no salary, giving simply an allowance of \$5 a month for laundry. When we ask our students to live at home, we shall probably contract to pay them a per hour fee for the hours actually spent in the hospital—somewhere between twenty and forty cents per hour.

The junior college course gives us the advantage of a college girl as our attending nurse. The enthusiasm of college life, the intelligence, the eagerness to learn are prominent in our students.

Your Hospital, Your Doctor and Yourself*

By ALLAN CRAIG, M.D., C.M.

New York

WE ARE living in a rapid and progressive age. Well-nigh revolutionary changes are taking place all about us from day to day. The modern machine is obsolete to-morrow. Business competition has become keen and unrelenting in its demands. We men and women must meet these demands upon our strength, courage and endurance with human bodies no stronger, if as strong, perhaps, as those with which our ancestors were equipped to face the exigencies of life. Generally speaking, their lives entailed more strain of manual effort, while ours attain their effect largely through the channels of the nervous system, which is perhaps more telling in its results, more insidious and more destructive in its reaction.

Our strenuous business men of the present day need to adopt the balloon tire principle and carry the same load with less pressure. Compare if you will the modern restless evening of many of our city folk with that so well depicted in Burns' "The Cottar's Saturday Night":

"His clean hearthstone, his thrifty wifie's smile,
The lisping infant, prattling on his knee,
Does a' his weary kith and care beguile,
And makes him quite forget his labour and his toil."

We formerly enjoyed of an evening the soothing strains of good music, which relieved our tired feelings and soothed us to rest. This was beautifully expressed by Longfellow when he wrote:

"The nights shall be filled with music,
And the toils that infest the day
Shall fold their tents like the Arabs
And silently steal away."

Can anyone for one moment imagine such an effect being produced by the wild calisthenics of a modern jazz orchestra? The drums, the crashing cymbals, the slide trombone, creating a desire to wiggle and squirm and shuffle one's feet, provoking physical effort and nervous excitement rather than rest and relaxation—do not these typify the modern tendency, especially in our cities?

While medical science has done much to eliminate disease, we must realize that battles are won not only by destroying the enemy, but by the constant strengthening of one's own forces. Medical science is a science of life and not alone a study of diseased bodies. Our hospitals are not simply brick and stone containers for the sick. The watchword of the modern hospital is, "Safety first for those who are ill, and stop, look and listen for all of us." In this "stop, look and listen" warning is to be found the most progressive idea of modern hospital effort.

Our statisticians tell us that one in ten of our people will be ill in a year's time and will require care that can best be provided in an environment especially prepared for that purpose. Of course only a fraction of this tenth will really receive hospital care for their ailments. Does our modern hospital render a service only to those who are sick? Must its efforts be limited to but one-tenth of our people? The up-to-the-minute hospitals of to-day are establishing a service for the nine-tenths who are not sick or at least if they are sick they do not know it. I refer to what is known as the inventorium idea, which means the establishing in your hospital of a department in which you may have a periodic health examination not because you are ill but because you wish to remain well.

How the Inventorium Functions

There is more of truth than fiction in the old statement that "the time to stop a thing is before it starts." In fact this is the basis for the activity and sound reasoning of modern preventive medicine. The periodic health examination strikes directly at the root of all disease. It goes further than any other means so far known to science for the solution of such problems as those of cancer and tuberculosis.

In the inventorium, which can be established in any hospital at comparatively small expense, the facilities of the institution, its laboratory and its x-ray service are placed at the disposal of the family doctor in order that his physical examination may be thorough, searching and accurate.

*A paper read at a public meeting in Brantford, Ont.

No slipshod, hasty, stick-out-your-tongue or take your temperature affair is satisfactory as a health examination. Would an automobile mechanic who looked at your car, noted the mileage on your speedometer and put his hand on the radiator to test its temperature have given that car a satisfactory overhauling? Would he know much about it? Could he tell you of the dirty spark plugs, the faulty piston rings or the sediment in the carburetor? Would he know why you could not get the proper pick-up from your motor? Of how much value, then, would be a physical examination by your doctor if he simply noted your mileage in life by asking your age, and your cooling facilities, by taking your temperature? The periodic health examination must be thorough else it will create a sense of false security and lead both the physician and his client sadly astray.

Comparative Data Are Necessary

The most searching and complete examination does not, however, fully meet all the requirements. The results of this year's examination must be available for comparison next year and the year after. In other words our physical diary must be written as we pass the milestones of life. You cannot write that diary but your doctor can and will. It is a part of his business to keep records for comparison and study. What measure of a man am I to-day and what measure of a man was I a year ago? How shall I stand a year from now? Are not these exceedingly important questions for all of us?

We are prone to think of all sickness in the light of disease, to associate our ailments entirely with the processes of germ life or chemical change. In so doing we may forget an underlying influence that takes toll of all of us day by day and hour by hour. That unavoidable influence is "wear and tear." You and I cannot escape it. Our hearts keep on pumping blood, our stomachs digesting food, our eyes seeing visions, our ears hearing sounds and our brains thinking thoughts.

These activities cannot go on indefinitely. Weaknesses are sure to show up and unfortunately those weaknesses are, as a rule, insidious at the outset. They can be discovered only after thorough investigation. Once found they can be guarded against. Let us remember that for the human machine there are no spare parts. The damaged heart can never be as good as it once was.

All this goes to show that our modern physician is not alone a healer of the sick, a peddler of pills or an expert in the performance of operations. He is a guardian of the lives, health and happi-

ness of our people. In fact, some day we may find it necessary to divide our medical profession into two great classes, those who will care for the sick and those who will care for the healthy, and the latter class will do their utmost to see that the former get as little business as possible. Now, both these classes of our profession are largely one but let me remind you that the doctor who thinks only of those who are ill is limited in his vision and narrow in his ideals.

Preservation and restoration are equally the mottoes of our modern hospitals and our conscientious doctors. Here is the text of their professional life.

The hospital is ours. It stands for our protection and for the protection of our families. It is an absolute necessity in the community, a definite part of both commercial and domestic life. As a result, we, as citizens, are obligated to support our hospitals both morally and financially.

The hospital is not a gold mine for the doctor. He receives no special financial reward because he treats the patient there rather than in the home. The advantages are largely in the interest of the patient, who finds there facilities for the diagnosis and treatment of his ailment that could not possibly be secured in his domestic environment.

What It Costs to Run a Hospital

At the present time it costs on an average about \$5 per day to keep a patient in a hospital, exclusive of medical care, and a large percentage of our hospitals find themselves decidedly out of pocket at the end of the year. Does this look as though they were money-making institutions? Think, if you will of the food, the laundry, the nursing care, and the thousand and one other provisions that must be available for the care of the sick.

Do you realize that it costs \$3,000,000 per day to keep the hospitals of this country open, \$125,000 per hour, \$2,084 per minute and \$105 every time you take a breath? The total amount of money invested in hospitals in the United States and Canada is approximately \$4,000,000,000 and this is steadily increasing.

It costs money to build and to run a hospital but it is money well spent. It will cost money to have that periodic health examination, to keep your physical diary accurately written, but should illness develop, the cost in cash, in loss of efficiency and in suffering will be far greater.

Many people to-day fear hospitals. They think of a hospital as a mysterious place from which emanates a strong odor of disinfectants, where one is permitted to speak only in whispers, where

white robed figures move silently and where those with uncanny powers, such as doctors and nurses, juggle with human life.

To-day people are asking for the truth about their hospitals, their doctors and themselves. The taking-for-granted attitude is a thing of the past. Plain facts are before us. Veiled statements in high sounding scientific terms are not satisfactory. It is no longer considered undignified for the doctor to talk in language that the layman can understand. Possibly the fad for crossword puzzles will help some of our people better to understand our doctors and our lawyers. What, for instance, is meant by a diagnosis? A friend of mine who is a well known magazine editor in the city of New York recently asked me if after all a diagnosis was not a scientific guess. A diagnosis means finding out what is wrong with you when you are ill, and if the methods used for this purpose are scientific there is no guesswork. When John Smith calls his doctor because he has a severe pain in his side, the doctor does not say "Mr. Smith, I fear you have a pain in your side." It is Smith's pain and he knows it better than the doctor.

Are You Using Common Sense?

The good physician will not only try to relieve pain but he will seek out the cause of that pain. Scientific medicine has provided means for investigation, for eliminating as far as possible the factor of error, and our modern hospitals have placed those means at our disposal. We cannot afford to be wrong too often when we are dealing with human life and human welfare. The captain of a ship does not navigate by guesswork or by intuition. He has charts, compasses, wireless and radio, in fact all possible means to insure safety. The proper instruments to insure the safety of your physical navigation are to be found in your hospital. Are you making use of them or are you sailing the sea of life blindly and simply guessing at the course?

The problems of health and disease are not mysterious. The days of charms and incantations are long past. We are living in a saner age of practical scientific achievement, based upon sound common sense and reasoning. Let me remind you that scientific medicine does not flaunt itself by flagrant advertising or cloak itself mysteriously, but studiously and conscientiously gives thought to the solution of the problems of life. The family medicine book and the almanac have not stood the test of time.

No patent or private right can be placed upon a scientific truth or an honest fact. There are no individuals with a special God given right to

heal the sick. The seventh son of a seventh son has no particular influence over the afflictions of mankind.

We are not endeavoring to prolong more or less indefinitely a period of unproductive and useless old age, rather are we striving to bring more healthful happiness into the world, more vigor and usefulness, more of the joy of clean living and clear thinking, which after all are the backbone of our national and economic life.

Telling the Public About the Hospital

How may the hospital carry its message to the general public? One of the vital factors in the upbuilding and expansion of the hospital is that of publicity—making the public acquainted with the activities and service of the hospital.

T. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., mentions five ways by which a progressive hospital may keep the public in touch with its work. These are through annual reports, hospital bulletins and news sheets, the local newspapers, National Hospital Day and speakers of service and business clubs.

The annual report provides valuable hospital data for a limited number of persons, particularly those who have served the hospital in various honorary or advisory capacities. It is not likely that the great mass of the public would be sufficiently interested to read the report understandingly.

Hospital bulletins and news sheets are particularly valuable in keeping up the morale of the hospital employees by making them realize that they are an integral part of the organization. To be effective such bulletins should be issued regularly, say monthly, quarterly, or even perhaps weekly.

Local newspapers offer by far the most important outlet for hospital news. Through the medium of a friendly press important facts regarding the hospital can be carried to thousands of readers and an attitude of interest and cooperation instilled in the minds of the public. Hospital directors should become acquainted with editors of the local papers, discuss publicity problems with them and seek their advice on matters of public interest. Since newspaper space is valuable, trivial items or uninteresting propaganda should not be sent to the newspapers. Any newspaper is always willing to use news, but it should be news.

National Hospital Day gives the hospital a splendid opportunity to secure favorable publicity and each hospital should make a point of celebrating the day. Visitors should be invited to the hospital and given an opportunity to see the work at first hand. Newspapers, too, are always willing to give space to publicity regarding the celebration of Hospital Day.

Speakers of service and business clubs can bring to their organizations the message of the hospital. A plan that has been used successfully has been to have each club give over, during the year, one entire program to the hospital problem or to public health in general. An interesting speaker can present the message of what the hospital is trying to do to promote human welfare and safeguard human health.

What It Costs to Make a Hospital Quiet*

By CHARLES F. NEERGAARD

New York City

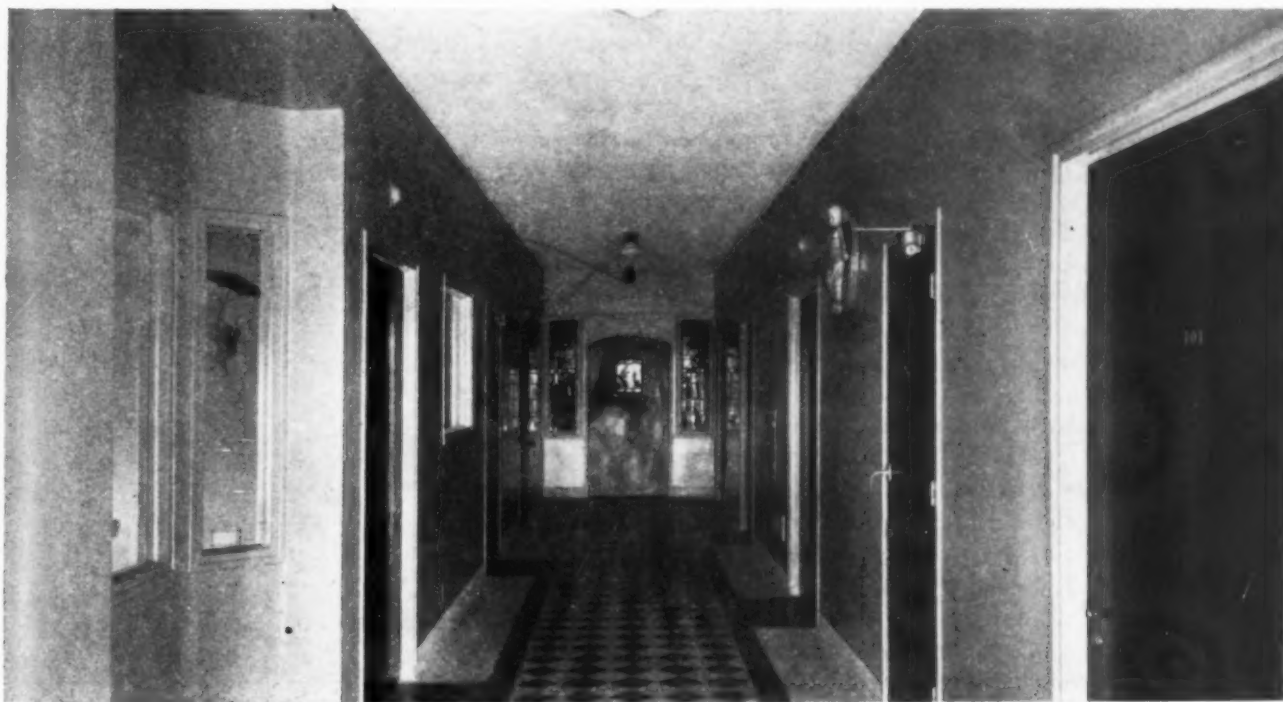
THE control of noise requires twofold precautions—acoustical treatment, previously discussed, which absorbs sound waves in the room itself, and sound insulation, the setting up of effective barriers around noise centers to prevent the sound passing through walls, floors and ceilings to adjoining rooms. The article that appeared in the March issue of THE MODERN HOSPITAL, dealt with hospital noises and considered, from the standpoint of the exacting requirements of hospital service, the various available types of acoustical treatment. An endeavor will be made here to outline simple methods of sound insulation practical for hospital use; to supplement the cost estimates and conclusions already given, and to answer, at least approximately, the questions that always arise in the minds of the members of a hospital building committee, when the subject of noise prevention or cure is presented. They recognize the necessity

for a quiet building but are inclined to be skeptical and ask, "What will it cost, to establish and maintain? Will the results be worth it? Will they be permanent?"

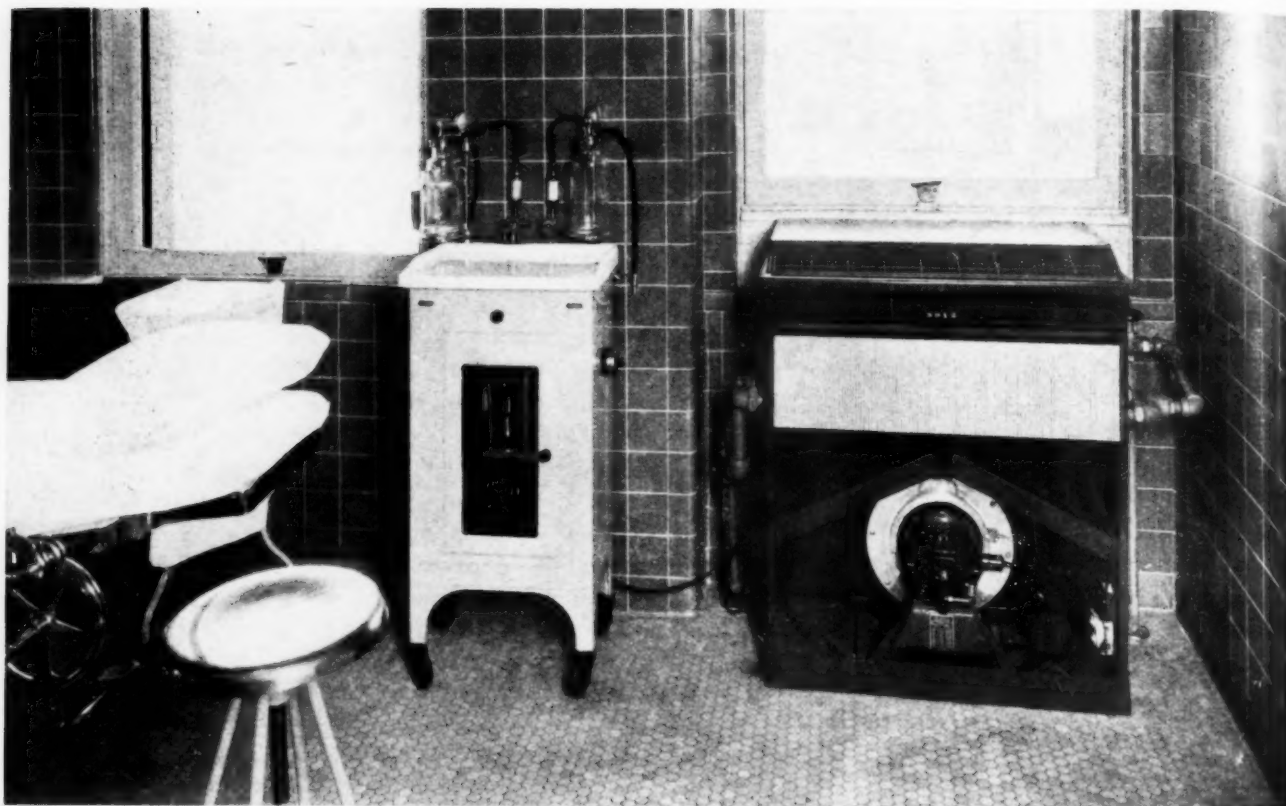
The fundamental principle of sound insulation, commonly called soundproofing, is to place obstructing media in the walls, floors and ceilings in the path of structural borne sounds, to break up the continuity of the building, which would otherwise carry the vibrations as readily as the air itself. Physicists and engineers frankly admit that there is much conflict between theory and practice, that expensive insulating precautions sometimes prove effective and at other times, under apparently comparable conditions, fail in results. Sound insulation is more a matter of actual field experience and general construction knowledge than of laboratory tests.

When we seek the most effective type of soundproof partitions and floors we are faced with the same situation that we found in trying to determine the best form of acoustical treatment—data

*This is the second of two articles on noise in the hospital. The first article appeared in the March issue.



Ceilings of Akoustolith plaster reduce corridor noises at Cottage Hospital, Grosse Pointe, Mich.



The ventilating unit in a small operating room, with front removed, showing the motor, fan, filters and fin radiator section.

based almost exclusively on laboratory tests. Measurements are not made on material actually installed in a building, but on sample panels. Thus important factors that immensely affect the soundproofing qualities of the partitions are not considered, for example, the construction of floors and ceilings, the presence of doors, pipes and conduits in the room, the location of partitions above and below.

Results of Investigators Vary

The results of different investigators vary widely, due to different methods of testing and the conditions under which the experiments are carried on. The manufacturer naturally quotes the most advantageous figure, and the purchaser who seeks to be convinced, finds himself lost in a maze of somewhat contradictory evidence. To quote Prof. Paul E. Sabine, whose research in problems of acoustics has been notable: "Compression waves in masonry travel with a velocity of about ten times the velocity of sound in air . . . certain sound deadening materials to fill the space between the floor joists and wall studs—mineral wool, cork, slag, felt and fibrous vegetable materials—have been employed often with disappointing results. Such materials do not afford sufficient improvement over an unfilled space to justify the added expense of construction. An unbridged, unfilled double wall with 2-inch air

space has about the same insulation value as $6\frac{3}{4}$ inches of solid brick. The same wall with a 4-inch air space is equivalent to about $10\frac{1}{2}$ inches of solid masonry. This presupposes, however, an ideal case of complete structural separation. Thus it appears that the problem of sound insulation in buildings is not a matter of damping acoustic waves in a medium, but of preventing the transfer of vibrations from one solid material to another."

In line with Professor Sabine's findings the new reverberation chamber of the Bureau of Standards Laboratories in Washington is constructed of double walls with a 4-inch air space between.

In building a hospital with a limited appropriation a sane balance must be sought between expenditures for insulation and absorption. So far as we could determine in the course of our studies, simple and comparatively inexpensive insulating precautions, intelligently applied, offer nearly as effective protection as more elaborate methods and will provide the average hospital with at least as much soundproofing as it can afford.

Sound control is a highly technical problem. Insulating measures and acoustical treatment are not only expensive but are likely to prove ineffective, unless their application is carefully planned and supervised. The hospital building committee and its architect should avail themselves of the

services of an experienced acoustical engineer, who will determine the character of the noise to be controlled and the most economical methods of accomplishing it.

Without going into further discussion of acoustics and the many systems of sound insulation that have been investigated, we shall outline the conclusions reached by describing precautions that have been incorporated in the plans and specifications of a new maternity pavilion, soon to be erected in New York City.

Soundproofing a Maternity Department

It would obviously be more convincing if the soundness of these conclusions could be demonstrated in a completed building, but as this is at present impossible, we felt that what had been learned might be of assistance to others confronted with the same problem, who have not the time to make detailed investigations.

The hospital is in a quiet neighborhood, so that there is no necessity for acoustical treatment to deaden noises that come from the outside when windows are open. For hospitals located in congested districts where there is heavy traffic, this is a matter of major importance, too often neglected when new buildings are planned. In designing this new pavilion, service and administration noise centers were located as remotely as possible from the patients' quarters, and insulation and acoustical measures were provided only for sources of uncontrollable noise, such as nurseries, labor rooms, diet kitchens and corridors.

Taking the same nursery, for which treatment for absorbing sound waves was described in a previous article, we shall complete the picture by outlining the special structural details adopted

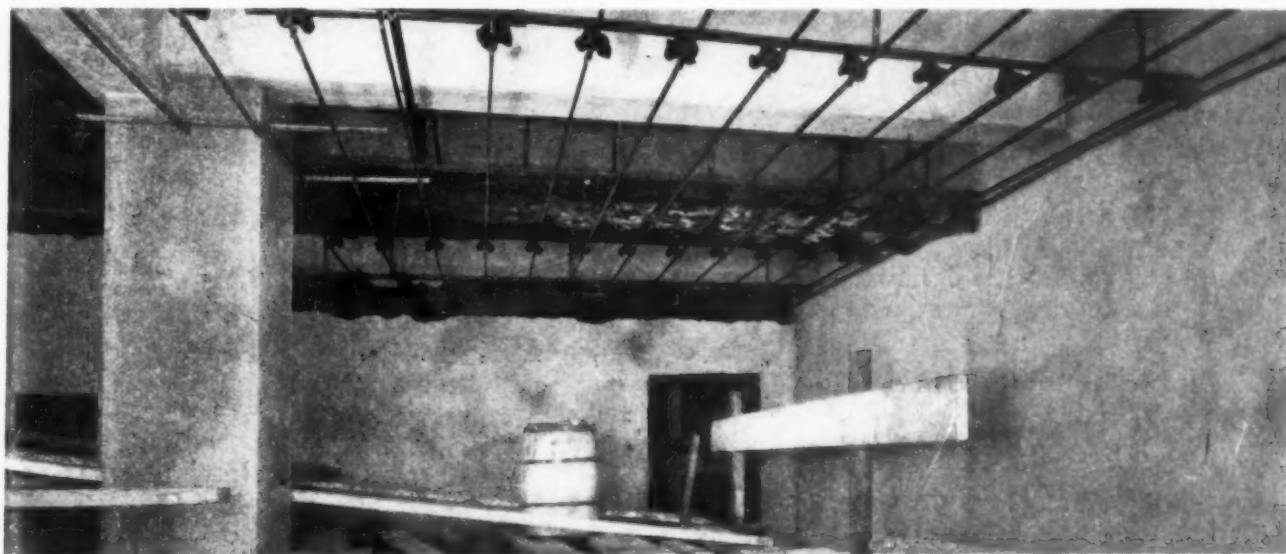
for insulation against the transmission of noise.

The floors throughout the building are of steel beam and girder construction, with cinder concrete slab 4 inches thick. Over the slab is spread 21½ inches of dry coarse anthracite cinders, which because of their porosity make a fairly effective sound deadening pad. On top of this is 2 inches of concrete mixed with a minimum of water, to serve as a binder and base for an inch of stiff mortar, on which is placed the finished floor. One of the soft floors is used, a combination of cork, rubber and asphalt, which can be scrubbed. Some engineers recommend the use of 2 inches of cork as a deadening pad. This costs 25 cents a square foot as compared to 10 cents for the cinders. The cinder pad will absorb some vibrations and will serve to insulate the partitions from the floor slab, and it was our conclusion that the results should prove effective in controlling the vertical sound waves, with the added provision of a hung ceiling.

Hung Ceilings Are Used

Hung ceilings will be used in all patients' rooms, supported on insulated hangers. These are made in two pieces with heavy felt between. If a hung ceiling is connected to the floor slab with rigid hangers it has little sound insulating value. While the special hanger adds about 12 cents per square foot to the cost of ceiling construction, it increases its insulating value 200 to 300 per cent over the conventional type of construction.

The partitions enclosing the room are formed of two separate walls of gypsum block with a clear, unbridged air space of 2 inches between. This, Professor Sabine has found, is as effective as the use of insulating materials between walls,



This illustration shows the structural details of a hung ceiling with insulated hangers.

either with or without air spaces. Obviously it is less expensive, except as to the amount of floor area covered.

In erecting the double walls care must be taken to avoid bridging. If there is any connection between them, even so much as one nail driven through, the vibration in one will be transmitted, as by a diaphragm, through to the other and will set it in motion. The two walls should be laid up on the dry cinder concrete and the top mortar floor brought up to them, not carried under. The walls should be laid simultaneously and precautions should be taken to keep loose mortar from dropping in between them and forming a link at the bottom. To prevent this a wood strip hung between the blocks to fill the opening, and raised as each tier is laid, is effective.

It is futile to undertake any sound control measures unless every detail is carefully carried out. If this construction is properly done, the only bridging between the double partitions will be the solid masonry, itself a limited conductor, exterior walls, floors and the door trim. The door frame to the corridors is anchored to the blocks and built in solid, 6 inches of steel and masonry. The door, of furniture steel, is 2 inches thick and cork filled. The door closes against felt gaskets on top and sides, which stop vibrations and fill the cracks, with an expanding rubber strip to close the bottom space at the floor. Thus the cries of infants are barricaded on all sides, save at the windows. If these are open, all other precautions are in vain, for the transmission of sound by the way of an open window from one floor to another is surprisingly efficient.

Improving the Ventilation

It was decided not only to keep the windows closed, but to provide double sash. This is made practical by the use of a combined heating and ventilating unit, which has proved highly successful in schools. A small noiseless fan draws in fresh air by a vent in the outside wall, passes it through filter pads over a steam coil and blows it up to the ceiling, where it is distributed without drafts to all parts of the room. Clean air, perfect circulation, as well as control of both temperature and air changes, are ensured. The device is not expensive to install or to operate. It is simple in design with all parts readily accessible for cleaning. Thus we overcome the problem of the open window and improve the ventilation of our nursery and labor rooms at one and the same time.

Further precautions provide for the covering with felt of all pipes carried through the room or its walls, and the filling with insulating fiber of all



This picture shows the construction details of a special sound deadening partition.

cracks around pipes and conduits, where they pass through the floor slabs. The principle throughout is to break up the structural continuity of walls, floors and pipes, and thus minimize the sound carrying vibrations.

All of the above comes under the head of sound insulation. Supplementing this, to blot up the myriad of sound waves that the shrill cries of infants set in motion we must have acoustical treatment. As a result of the investigations and experiments described in the preceding article, alternate proposals for acoustical treatment are called for, specifying either Nashkote B, consisting of 1 inch hair and asbestos felt covered with finely perforated oilcloth membrane, or Acousti-Celotex, 1¼ inches thick, the final decision to be based on appearance.

According to the studies previously described Acousti-Celotex costs less for upkeep and maintenance and has a lower installation cost per unit of absorption. It has therefore slight economic advantages for hospital purposes. The latest development of Nashkote B, using white felt under the membrane, is however, superior in appearance to Acousti-Celotex with its many large holes. If the experiments now being carried on produce a color scheme that will successfully camouflage these holes without serious loss of light reflection,

the weight of evidence would be slightly in favor of Acousti-Celotex.

From the standpoint of absorption there is but little difference. Each square foot of Nashkote B absorbs 64 per cent and of Acousti-Celotex 70 per cent of the sound waves that would pass out of a

COMPARATIVE TABLE SHOWING COST OF SPECIAL STRUCTURAL ITEMS AND COST OF STANDARD CONSTRUCTION
Soundproof Standard
Items Construction

Nursery 15'x38' with 10'6" ceiling 360 sq. ft. of double partitions vs. single wall.....	\$ 393	\$254
2" soundproof door, with felt and rubber gaskets vs. ordinary hol- low metal door.....	56	43
Additional inside steel sash, frames and transoms for three 4'x7' windows	180	...
The hung ceiling is standard in each case. Additional cost for insulated hangers at 12c a sq. ft.	54	...
Special heating and ventilating device substituted for an ordi- nary radiator	320	75
450 sq. ft. of acoustical treatment at 80c vs. 3 coats ordinary plaster, less finished coat of plaster	360	57
Pipes are felt covered in both cases		
	\$1363	\$429

room through a square foot of open window. For corridors, diet kitchens and utility rooms acoustical plaster with at least 30 per cent absorption is called for.

The side wall of our nursery, which is 30 feet long and 10 feet 6 inches high, comprises 315 square feet, so that we shall have a result fairly comparable to a room with only three instead of four walls for the sound waves to carom back and forth against. These are the precautions taken to ensure our patients against disturbing noises from the nursery.

Now as to expense. The accompanying table summarizes the cost of the various special structural items as compared to standard construction. It will be seen that we are spending an extra sum of \$934 to control the noises in one nursery.

\$10,000 Budgeted for Noise Control

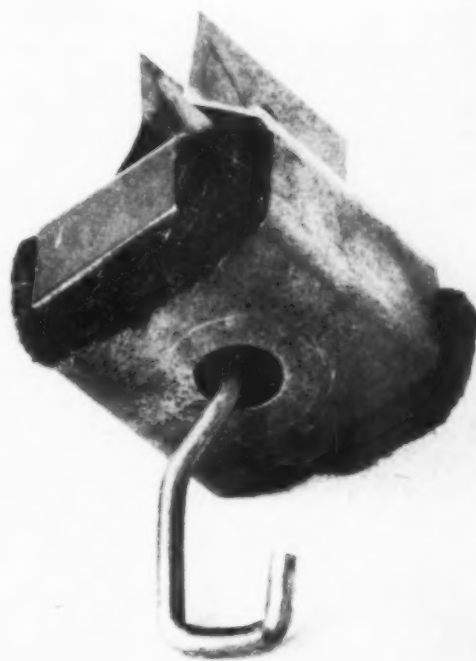
The maternity pavilion under discussion is an addition to an existing hospital. It is a building of four and one-half stories and basement with a maximum capacity of seventy-five beds on the three upper floors. The delivery suite is in a half story on the fifth floor. The building contains 388,500 cubic feet or an average of 5,466 cubic feet per bed, which is comparable to the majority of modern compact general hospitals. For this reason the cost of making this building quiet is fairly suggestive in its application to hospitals in general. When the preliminary budget for the

new building was prepared, \$10,000 was included for the control of noise. We aimed to expend this wisely. No attempt was made, as is so often done, to insulate all partitions on the patients' floors, the treatment being limited to those around sources of uncontrollable noise in close proximity to the patients' rooms. Three nurseries, two labor rooms and two delivery rooms were designed as the nursery above described. Acoustical plaster was specified for the ceilings of the diet kitchens, utility rooms and 480 lineal feet of corridors on the patients' floors.

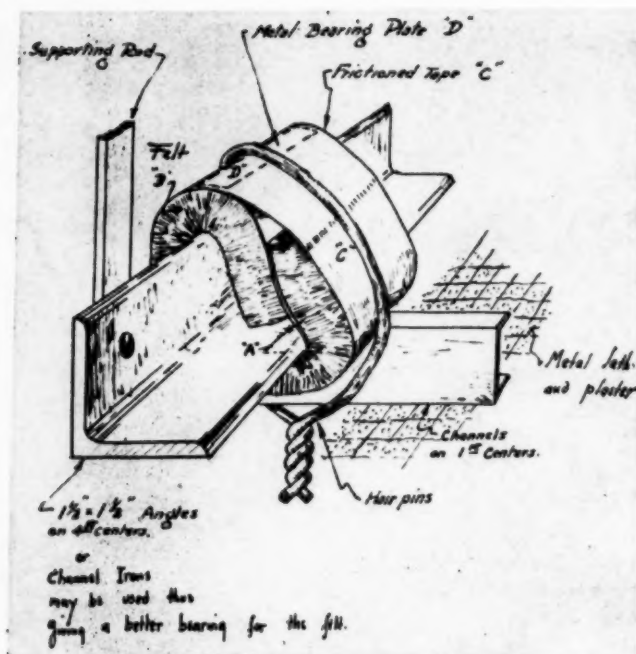
According to the preliminary estimate of the builder, the total cost of all the sound control measures described will be \$7,967. For seventy-five beds this represents an extra investment of \$108 per bed. The cost per cubic foot is increased a trifle over 2 cents, and the total structural cost about 2¼ per cent, surely a moderate price to pay for permanent quiet.

Prevention Is Cheaper Than Cure

All of the above treats of preventive measures in a new building, and prevention rather than cure is a policy that applies to noise as well as health. Corrective treatment to deaden noise after a building is finished, which must usually be limited to sound absorption, is as a rule more expensive though not necessarily less effective than preventive measures incorporated during construction. The ceilings and walls are already plastered, if the plaster is weak it may have to be removed. In an old building felts and fibers repre-



A type of insulated ceiling hanger.



Another type of insulated ceiling hanger.

sent the most practical form of absorption treatment.

Supposing noise from an old nursery disturbs the patients above, below and on all sides, if sound insulation cannot be installed, the area of acoustical material must be large. While acoustical treatment does not appreciably prevent sound transmission from one room to another, it quiets the noise in the room where it is applied by absorbing a proportion of the sound waves and thus lessens the number of such waves that will be transmitted.

Adequate treatment which costs, say, \$500, should last indefinitely, but let us assume its life is only ten years. The cost to the hospital in depreciation and interest, with an added \$20 for extra expense in cleaning and painting, is \$72 a year or some 20 cents a day, to ensure freedom from disturbance from infant cries. If twenty beds are within hearing, the cost of relief is 1 cent a bed a day—certainly not an extravagant figure.

Hospitals admittedly already cost enough to build and maintain without the introduction of items of additional expense. However noise of all kinds is on the increase. Quiet is an essential that modern hospital service cannot afford to disregard and, as we have demonstrated, it can be achieved at a reasonable cost. Our many months of study will not be in vain if others are stimulated to go further and develop measures to meet more adequately the needs of the hospital fields; if even a single hospital shall apply the conclusions we have outlined and provide a quiet peaceful refuge where disturbing noises have no place.

Editorial Charges Prejudice Is Incited Against Autopsies

That an attempt to incite prejudice and malice against postmortem examinations is being made by the Chicago Undertakers' Association, is charged in an editorial in the *Journal of the American Medical Association* for March 9.

According to the editorial, the undertakers' association has been circulating questionnaires among families of persons who have availed themselves of the services of association members. Among other questions, were those that asked whether or not the deceased was attended by a physician, whether or not an autopsy was performed on the body and by whom, whether or not consent was obtained for the autopsy, the nature of the autopsy and the condition of the body thereafter. The questionnaire concludes with: Will the nearest relatives and next of kin consent to bring suit against those participating in and responsible for said unwarranted and illegal autopsy?

"Here," says the editorial, "is clearly an attempt to incite prejudice and malice against postmortem examinations. Apparently also the undertakers' association would urge families to bring legal action against any one participating in and responsible for an autopsy. The campaign for recognition of the scientific value of postmortem examinations has been a difficult one, a constant battle against prejudice."

Speaking of the change in name from undertakers to morticians, with the consequent elevation of the profession, the editorial says: "Until the morticians learn to appreciate the significance to the living of proper scientific study of the dead, they will continue to be simply undertakers regardless of the name by which they may call themselves."

Emissaries for the Hospitals? No, Says Indiana Doctor

"It is neither consistent nor in good taste to have emissaries out proselyting for the hospitals," says the editor of the *Journal of the Indiana State Medical Association* in the February issue of the magazine, in which he comments on a complaint by an Indiana physician that the University of Indiana hospitals are sending out bulletins far and wide containing fairyland stories concerning the wonderful results accomplished for patients.

"The university hospitals are for teaching purposes and are a part of the medical center that will eventually constitute the medical department of the university," the editorial continues. "If any private hospital in Indiana would send out such a bulletin as has been sent out repeatedly by the Indiana University hospitals, every reputable physician would shun that hospital on the ground that the hospital was exploiting itself through advertising considered in very bad taste."

"No one who is intelligent and who is conversant with the facts can deny that the university hospitals in Indianapolis are doing high grade work and the members of the regular medical profession, individually and collectively, should recognize the fact that the university hospitals afford a place for the proper care of suitable patients who are indigent and who cannot be given appropriate care at home, but we quite agree that it is neither consistent nor in good taste to have emissaries out proselyting for the hospitals."

The Real Meaning of Research and Why It Should Be Encouraged*

By ALPHONSE M. SCHWITALLA, S.J., Ph.D.

Dean, St. Louis University School of Medicine, St. Louis

RESEARCH is a bugbear to some people; a shibboleth to others. Some have found it an incubus; others have found it the guiding torch of truth. Some regard it as a gift of the gods; others find it the millstone on the neck of progress. Misunderstandings on this score have been beyond number.

And yet the fact is definite and clear, simple and unmistakable, that research among all human agencies has been the outstanding factor in the material development of our civilization. Research is after all nothing but the quest for truth. Without that quest we cannot uncover the mysteries of nature; we cannot delve into the meaning of life; we cannot envisage the hopes of the future, and we cannot draft programs for the betterment of mankind. Misunderstandings have arisen, it is true, regarding the types of research. In the minds of many, research evokes a vision of complicated machinery, elaborate equipment, huge laboratories, large personnel, extravagant budgets. Yet none of these things is essential to the concept of research or to its success. A photographic plate and a piece of tungsten were the equipment from which radiography was developed and from this the whole theory of radiant energy was contributed to theoretical and practical physics. A test tube in the hands of one may be a more powerful instrument than the most complicated set-up in the hands of another.

When we come to speak of research in the hospital, we carry into the hospital world the prejudices, predilections, the bigotry and the al-

legiance of the people at large. For after all superintendents of hospitals, members of boards, members of the lay and professional staffs and nurses are human beings and they share the ideas as well as the psychoses of the popular mind. They may under favorable circumstances have lifted

themselves above the general convictions, the general fears and hopes, but we must not expect from them, taken as a large group, the highest manifestations of scientific idealism.

And so while it seems a truism to say that the hospital must encourage research, there still remains the large task of making the implications of that statement clear to the individual hospital administrator, to the board member, to the staff member, to the nurse. Research is a

process but it is also an atmosphere. Let me speak of it first of all as the latter, an atmosphere that pervades an institution, that fills with a life-giving influence the hospital activities, that stimulates thought and actuates policies.

The hospital is a depository of human problems. Each patient that passes the admission desk comes into the hospital as a living question mark, which theoretically at least is to be erased before the dismissal blank has been filled out. In regard to each patient, the complex mechanism of the hospital is set in motion in the quest for the truth behind the question mark and when that truth is discovered, a contribution is made to the sum total of human knowledge.

The research atmosphere is unescapable in an institution seeking to view its problem in such a light. The problem may be an oft repeated one, a million-times-told tale, yet with our modern concept of individualization and disease, it be-

The Quest for Truth

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*Read at a joint meeting of the Hospital Association of the State of Illinois and the Wisconsin Hospital Association, Chicago, February 20, 1929.

comes progressively clear that each patient is a law to himself, presenting phases of a disease, complications, indications and contra-indications without number. A fundamental principal of the law of variation as interpreted by science statistics is that the uniformities in a varied assembly of things can be discovered adequately only when the individual cases have reached a sufficiently large number. In this sense every hospital, be it large or small, can make its contribution to the sum total of human knowledge by developing in the members of its staff, medical as well as nursing and administrative, the feeling of responsibility, first, for discovering the meaning of a particular disease and second for making this accumulated knowledge accessible to the professions at large through reports and publications.

Saving Many Lives

In a hospital in which this quest for truth is active, its effect is noticeable in the general tone of the administrative and professional personnel. In fact if there is one feature that differentiates a lethargic from an enthusiastic institution, a hospital that does its duty as contrasted with a hospital that enjoys its duty, it is the fact that the latter type of institution considers its patients as human problems to be solved by the full expenditure of energy and resources. A human life saved is more than one human life saved, it may mean the lives of countless others saved through the accumulated and integrated experience gained through that process of saving. Surely, then, a hospital must encourage research.

Must a hospital also encourage research as a process—formal research? In answering this question we may again subdivide our problem into two, for statistical research differs from experimental research. I might grant for the sake of argument that all hospitals, especially those that are limited in resources, may not be able to undertake some of the larger programs of experimental research, but I cannot grant that even the smallest and the poorest hospital can be excused from accepting the privilege of making at least a minimum contribution to the sum total of knowledge concerning the human organism through the statistical research it is able to carry on.

What we ordinarily understand by clinical research often takes the form of a report of so many cases of a particular class of disease. Has this value? Surely, speaking generally, we shall all agree that it has. Therapeutics, again speaking generally, can be evaluated only when we know whether the success of a certain procedure exceeds the average of success in the control of cases of that particular kind. One physician or one

group of physicians cannot supply such data. The statistics must be gathered from every known quarter and the more agencies that contribute to the accumulation, the safer becomes the application of a method or a process to the treatment of human beings. This kind of research even the smallest hospital can conduct.

There is, however, another form of clinical research regarding which question might arise. The twilight zone of human knowledge becomes progressively illuminated through the shafts of light that are pushed into the darkness. A new discovery, a new application of an old discovery, a modification of an old method, these and many similar processes may hold untold possibilities for saving the lives and preserving the health of human beings. Surely the hospital may encourage this sort of research and should encourage it if the hospital is to make available to its patients the benefits of scientific discovery. Perhaps the term research is stretched too far in its meaning as applied to such a state and condition but an example will illustrate my meaning. Suppose that after the first announcements concerning the efficacy of insulin the hospitals the country over had waited until insulin treatment had been tried under the rigid condition that obtained in the larger hospitals and in some university hospitals, surely many a diabetic would have lost his chance to regain health. Instead, medical men in every quarter of our land undertook the application of the new discovery to all available cases of diabetes. It is true mistakes might have been made and perhaps the history of failures in this field might form an illuminating chapter, but without doubt alleviation of suffering was brought to many.

Taking Advantage of Scientific Discoveries

And what is true of insulin is just as true of countless less sensational procedures of which our research journals and our medical publications bring almost monthly record. I am not making a plea here for rashness or for misguided scientific zeal or for precipitancy, but every hospital administrator can enumerate cases that would undoubtedly have profited by the application of new procedures and perhaps might have been completely cured if the staff of the hospital had been quick to avail themselves of the latest contributions to science. While this may not be creative research, it is applied research, research into the limits of applicability of a given procedure to individual variations of a given type of disease.

There is another form of research to which I wish to call especial attention. Our hospitals have ceased to be merely institutions for the restoration of health and for the preservation of health;

they have become schools, of a specialized kind to be sure, but still schools—schools for patients, schools for interns, schools for nurses, postgraduate schools for practitioners. Some hospitals by their public pronouncements have manifested their consciousness of these educational responsibilities and all modern hospitals, even the smallest, are alive to them.

In this sense the hospital affords an experimental population in which to solve countless problems in adult and child health education, in methods of teaching theoretical and practical medicine and nursing, hospital administration, hospital interrelationships, public health, community, civic, state and national health responsibility. Practically every hospital, whether it be situated at the crossroads or in the midst of the bustle of the city, can make a contribution towards one phase or another of the numerous ramifications of hospital influence. None of these problems will find a final solution, it is true, because changing circumstances and changing times will continue to modify many seemingly final conclusions, but out of the welter of opinion and partial experience, there may develop a general psychological attitude and some principle may be adopted that will mark a turning point in hospital history.

Man Is Not a Laboratory Animal

Now let us consider the highest type of research possible in a hospital—formal, experimental, creative research. This, I am willing to concede, is not possible in all types of hospitals. There may be restrictions of budget and of personnel that will prevent the pushing onward of scientific thought through such types of research as are ordinarily performed in research laboratories. Even in this field, however, those hospitals that can afford the facilities, must and should be encouraged to enter upon a project proportionate to their means. The sick human being, it is true, is not a laboratory animal but neither is he so isolated in his human glory that he must be regarded as completely outside the possibilities of sane, carefully controlled, watchfully supervised experimentation, which may bring health to himself and health to countless other beings. I am aware that this question must be approached with the utmost delicacy, but I can well imagine circumstances arising in which, given the knowledge and skill of the physician and adequate facilities, a reasonable experimentation might well be regarded by the patient himself as a privilege that he would not, were the matter carefully explained, care to forego.

There is another form of research that cannot be too strongly insisted upon. Every autopsy is a

solution of a research problem. The unknown factors in a disease are often uncovered by a carefully conducted postmortem examination. If the contributions made to the knowledge of medicine through autopsies could be heaped together, surely they would prove to be greater than those that came through many of the other forms of medical research. The responsibilities of hospitals in this field have been extensively stressed in the last few years and they will receive an added emphasis through the recent demands of the American Medical Association. But autopsies will be useful only insofar as they are conducted by men adequately trained and are reported by men equally well versed in the various medical sciences upon the knowledge of which an autopsy may draw. We may insist upon autopsies but that insistence alone will not advance medicine. We must stress the responsibilities for making the knowledge gained through autopsies accessible to ever widening circles of students.

Upon whom do the responsibilities for research in the hospital finally rest? The answer to this question, it seems to me, must be unequivocally given—it rests squarely upon the chief of staff, and in hospitals in which there is departmental organization, upon the directors of departments. In my opinion this is not a matter in which the superintendent of the hospital can play a leading rôle. It is well enough to talk about research in the hospital, but research cannot be conducted by inadequately trained men who cannot see a problem or who having seen the problem are blind to its implications or to the avenues by which it may be approached.

When Tact Is Essential

I know that this matter is beset with difficulties. Departmental directors are frequently men of an older school, men who held sacred the healing functions of medicine and men to whom the teaching function of the practitioner was a self-gratifying luxury. Such a man may have under him a subordinate who comes from a modern medical school, himself vibrant with the verve of discovery, himself perhaps an author of no small achievement. Even in this case, I believe organization demands the mutual subordination of viewpoints, psychological and social adjustments, without stifling the ambition of the subordinate. The medical man who has graduated within the last fifteen years has been trained, at least in a rudimentary way, in the intricacies of research. Given the chance and the environment, he will allow his investigative powers their legitimate exercises and I would bespeak for the ardent tyro, the paternal guidance and helpful encouragement of an en-

lightened director. Lucky the hospital in which the entire staff is imbued with the enthusiasm for contributing to our knowledge of human disease.

And what is the rôle of the superintendent and of the board of directors in this undertaking? They should, first of all, become keenly alive to the hospital's responsibility for making contributions to knowledge. These contributions may have merely local significance, they may afford stimulation for the local medical society and its members or for the local population. But they have greater value if in addition they extend the influence of their hospital to ever widening circles. Secondly, I would say that it is the function of the superintendent and of the board of directors to see to it that the staff includes as many men imbued with the spirit of research as the geographical location of the hospital, the available finances and the facilities allow.

Hospitals Can Learn From Schools

Thirdly, the superintendent and the board of directors should try to create better and better facilities for the prosecution of research and should seek to rise from one level to a still higher level of scientific achievement. Fourthly, the superintendent and the board of directors should make it their business to point out problems from time to time as they are suggested by the conditions in the institution. Schools, colleges and universities have learned the importance of self-surveys, exhaustive or partial, periodically conducted. It is amazing how much such self-surveys have contributed to pedagogical theory and to school science. Hospitals, if they wish to meet their responsibilities should adopt similar methods.

Fifthly, the superintendent and the board of trustees should give the opportunity for research, and without invading the field of professional medicine, should wisely and cautiously direct the minds of the members of the staff to a deeper and fuller appreciation of the research attitude. They should put at the disposal of their staff members, libraries and laboratories, books, instruments, personnel, which will, by their very availability, galvanize scientific indolence into industrious activity.

Will the patient be lost sight of in all of this? Emphatically, no. The patient must ever remain the center of the hospital. It is, after all, for his sake that scientific achievement must be pushed to the ultimate limits of professional knowledge. The patient's life, his health, his safety are foremost, but none of these can be secured unless someone, somewhere, sometime is engaged in the type of activity I am here advocating.

Points in Organizing a Children's Hospital

The form of construction and a site affording plenty of sunlight are points to be considered in building a children's hospital, according to Dr. James B. Cutter, director, Children's Hospital, San Francisco. Formerly the pavilion type of architecture was popular, but the modern tendency is not toward the pavilion type of construction. Both types have their good points, Doctor Cutter says.

The unit of operation of the hospital, about which the whole organization should be built, upon which all of its activities must ultimately converge is the patient. Only through the patient can the hospital find its fullest expression of service.

In the social service and out-patient departments are sought scientific knowledge of human nature and the social fabric of which it is the warp and woof. The methods of attacking these intricate and complicated problems have become highly specialized and are doubly important in connection with children's hospitals.

In the clinic is found the pulse of the hospital circulation. Its competent and regular medical organization is of prime importance, with the work divided into medical, surgical, orthopedic, otolaryngologic, including the following departments: dermatological, cardiac, syphilitic, neurological, psychiatric renal and pyuric diabetic and an ultraviolet ray laboratory.

How to Find the Right School for Nurse Training

How should a girl who wants to enter the nursing profession go about finding the right school in which to get her training? Elizabeth G. Fox, director, public health nursing service, American Red Cross, asks this question and answers it in an interview published in the January issue of the *Forecast*.

"She should apply to the state board of examiners for a list of accredited and leading schools," Miss Fox suggests. "She can get a statement from them as to what points to look for in the school she chooses. Her preliminary training is very important. The more education she has, the more chance there is that she will make an intelligent nurse. The best nursing schools require at least graduation from high school, and some require two years of college. About a dozen colleges are now giving a five-year training leading to a bachelor's degree and a nursing degree also."

Choosing a Credit Officer for the Hospital

The credit department of the hospital should preferably be in charge of a trained social worker, J. R. Mannix, superintendent, Elyria Memorial Hospital, Elyria, Ohio, believes. The duty of such a worker would be to arrange for the type of accommodations, to plan terms of payment, to grant special rates to patients unable to meet the full cost and to approve those unable to pay. A sympathetic credit officer seeing all patients at the time of admission will give the patient an impression of the hospital that will not soon be forgotten.

Library Building Serves Dual Purpose

By L. A. SEXTON, M.D.

Superintendent, Hartford Hospital, Hartford, Conn.

STEP by step hospitals have come all the way from poorly appointed institutions of last resort for the indigent to veritable palaces equipped with all the luxuries and countless conveniences not to be found in the home of the well-to-do. Methods are being constantly sought by which the minds of patients may be diverted into wholesome channels, and brains that are worried with pursuing

Right, the new library and residence building.



their own ideas around and around may be restored to their normal functions as their bodies convalesce.

Hospitals may no longer be of the somber prison type. They must take on much of the character of the age in which we live, and more and more as time goes on they will have to adopt novel methods of diverting minds while wrecked bodies are being restored.

Among the new

Below, the main reading room of the library.





A private reading room for physicians is an attractive feature of the new building.

things that have already made their way into our institutions are the occupational therapy department, the radio, the hospital reader and the library. What is to follow in this age of wonders we dare not predict. Probably the most important of all these is the library, which should be bountifully supplied with all types of reading matter for the patients. In addition it should contain for the convenience of the attending and house staffs all the modern medical books and literature. A separate library should be in every nurses' home.

Late in 1927 the president of the board of trustees of Hartford Hospital, Hartford, Conn., announced that he and his daughter would meet the cost of the erection of a library for the hospital. For many years the living quarters of our house staff had given us much concern and it was decided to include in this building quarters suitable for their use.

The type of architecture decided upon was the Bulfinch. The building, which is of brick and stone, is 30 by 60 feet in size, and has three stories and basement. The basement is to be used for book stacks and a pool and billiard room for the interns.

The main floor is devoted entirely to library purposes. There is a room, 12 by 18 feet, set apart for current medical books and literature for the benefit of physicians who wish to avail themselves of these without being disturbed.

The second floor consists of eight living rooms for the interns and one large reception room. The third floor consists of nine living rooms for the interns. There are ample toilets and baths on each floor and each of the living rooms has its own telephone, and hot and cold water.

Finding Suitable Jobs for the Tuberculous

A three-year experiment in "medically supervised employment for patients recovering from tuberculosis," conducted by the New York Tuberculosis and Health Association, is summarized in a book just published by the association. The study, written by Alice Campbell Klein and Dr. Grant Thorburn, concludes that "there are no industries in which all jobs are suitable for the tuberculous, and on the other hand there are only a few industries that have no jobs suitable for the tuberculous."

Another conclusion derived from the experience with more than 900 former tuberculosis patients is that it is not feasible to list trades and jobs that are suitable for the tuberculous, but rather to list the factors to be avoided and those to be sought in selecting work for such persons.

The book, entitled "Employment of the Tuberculous," contains a detailed report of this, the only such experiment thus far conducted under the intense, active and natural conditions of work in offices, stores and factories in New York City.

The expenses of the experiment were borne jointly by the New York Tuberculosis and Health Association and the Laura Spelman Rockefeller Memorial.

How Social Worker and Dietitian May Cooperate*

By MARGUERITE L. SPIERS

Director of Social Service, Berkeley Health Center,
Berkeley, Calif.

THAT a definite relationship exists between the social worker and dietetics is now generally recognized among health workers. We shall therefore take the relationship for granted and proceed to analyze certain factors involved in it, which are the common concern of social worker and dietitian, limiting our analysis to the factors that are social in nature.

The type of dietitian here discussed is one connected with an out-patient service, who assists the physician in the field of applied dietetics, as it relates to food treatment and health education.

The fundamental thing common to the departments of dietetics and social service is their existence as units of a more or less complex organization, directed by one person—the physician—for the welfare of the patient. In the highly specialized process of medical care, the dietitian and the social worker each finds herself responsible for a circumscribed part, with boundary lines interwoven.

Problems the Dietitian Must Solve

In her work the dietitian is constantly meeting obstacles in the way of successful treatment, to overcome which requires careful social diagnosis and treatment before the dietetic department can accomplish successful results.

The following are a few such problems.

1. *Economic Insufficiency*, which may be due to a number of different causes, such as:

(a) *Inadequate income for size of family.* Here the breadwinner may have steady employment but may have reached his maximum earning capacity, while the size of the family has grown beyond his ability to provide adequately for its needs. It is obvious that successful food treatment for any member of this family will depend upon the social worker's ability to rearrange or supplement the food item of the budget.

(b) *Poorly spent income.* This may be caused by poor judgment, ignorance of budgeting, carelessness or mental incompetency. The social treatment in this case will depend upon one of

several possible social diagnoses. It may consist of reeducation as to the relative value of the food item in the family budget, education in relation of food to health, training in budgeting, in the purchase, selection and preparation of food, and possibly training of a mother in the mental hygiene aspects of food habits in children. On the other hand, the family may be unable or unwilling to learn, and the social treatment indicated may be only palliative. It may mean removing the patient from the home, if the home cannot meet the minimum standard necessary for the health of that individual.

(c) *Unemployment.* If the patient is the breadwinner, finding suitable employment will involve a process ranging all the way from securing sheltered employment, to gradual return to full-time work in his old job. Or it may mean vocational training in a new field of work that meets the requirements of a physical limitation.

(d) *Dependency*, accompanying old age, death or desertion by the breadwinner or the parents of minor children.

(e) *Physical handicap for industrial life*, caused by disease or accident.

2. *Broken Homes.*

3. *Problems Arising From Alcoholism or Drug Addiction.*

4. *Social Problems Associated With Mental Disability*, such as mental deficiency; mental disease; various neuropsychiatric conditions; emotional and volitional instability; social maladjustment and social conduct.

5. *Superstition, Fear, Ignorance.*

This is a vicious circle that often blocks all attempts to arrange treatment of any kind, and is apt to be so intangible and deep-seated that correction is not easy. This is sometimes the type of case that is so difficult at the outset that it is closed for "poor cooperation," without receiving the social study and case work that might break down these barriers.

6. *Racial Customs or Religious Beliefs.*

Often the diet recommended conflicts with beliefs and customs of patients and it is necessary for the dietitian to work it out in terms of food

*Read at the convention of the American Hospital Association, San Francisco, August, 1928.

to which the individual patient is accustomed. Here the social worker can assist by presenting as a part of her social history the racial and religious background of food clinic patients, and, where food budgets must be supplemented, by providing for the type of food these patients will be willing to eat.

7. *Problems Relating to the Environment.*

These include situations at school, in industry, home life, housing and standard of living.

8. *Foster Home Problems.*

9. *Lack of Family Home.*

The foregoing is not an attempt at complete classification of medical social problems. This has been done in such studies as that made by Miss Gordon Hamilton.¹ Our outline here is intended to cover some of the typical and outstanding problems that occur in the dietetic treatment of patients.

From what has been brought out, it appears that there are certain definite things a social service department can do to assist the department of dietetics, namely, providing social diagnosis and treatment for food clinic patients. The function that goes hand in hand with this is furnishing the dietitian with social data that will aid her in planning her part of the treatment.

The question that then arises is how this assistance can be secured for all needing it. In this connection two points should be mentioned—fundamental training and plan of organization.

What Mutual Understanding Will Do

The necessity of each group understanding the work and technique of the other calls for some general training in the fundamentals of social work for the dietitian, and, for the social worker, appreciation of the part played by food in health and disease and a knowledge of the fundamental aspects of dietetics and nutrition. With such mutual understanding and knowledge, they will constantly work together, and good team work will be possible. Without this knowledge, social problems will be liable to slip through the dietitian's fingers and situations with a definite food significance will escape recognition by the social worker.

There should be some provision for routine referring of patients back and forth. The plan of the food clinic at the Boston Dispensary, Boston, is one that will bear careful study and consideration in this respect. This has been described in detail by Frances Stearn.² Some hospitals have met the question by having a dietitian as a member of the social service staff. Others assign a

social worker to the food clinic. Whatever the arrangement, the machinery should be such as to facilitate the clearing of every patient through the social service department and the dietitian should be able to call upon the social service department at any time when special needs arise.

Team work of dietitian and social worker seems essential to the treatment of dietetic cases. From the social service side, this is true because of many social problems presented by patients for whom the dietitian must plan. These problems, if unsolved, may act as obstacles to successful treatment.

Best results can be obtained when the social worker and dietitian each has an understanding of fundamental principles of the other's profession.

When a health agency offers its dietitians the service of a medical social worker, it creates machinery for a well rounded study and treatment of its food clinic patients.

Treating Illness Psychically and Socially as Well as Physically

If we want to find out why people are as they are, we must dig deeply into the psychic and social factors as well as into the physical.

Dr. M. C. Winternitz, dean, Yale School of Medicine, in speaking of the work to be undertaken by the Human Welfare Group at Yale, says:

"The time has come when physicians must realize that physical illness cannot be treated successfully by itself. Medical students must be taught so that they may begin to get back some of the attributes of the old family doctor, who, consciously or unconsciously, took into consideration the mental and social factors in the lives of his patients and did more good, perhaps, because of his attention to these nonphysical aspects than he did through his knowledge of organic disease.

"I do not mean that specialization must be given up. It has been made necessary by the tremendous expansion of knowledge, particularly in chemical and bacteriological fields, which followed the scientific discoveries of fifty years ago. Through specialization many specific diseases have been conquered and the span of life has been materially lengthened. But, in the meantime, psychic and social problems have been largely neglected, and they must now come in for a consideration as adequate at least as physical well-being has been accorded. A sound scientific basis and a proper coordination with other fields of human behavior must be effected for the treatment of mental and social maladjustments.

"There are to-day more hospital beds in this country occupied by the mentally disordered than by the physically ill, and the number of patients in institutions for mental diseases and feeble-mindedness is increasing. The suicide and homicide rate is tending upward. Divorce is increasing. Crime is rampant. Does this not show that the problems of human welfare are not being met effectively? Does it not mean that sociologists, economists, psychologists, psychiatrists and physicians must work together?"

¹ Hamilton, Gordon, *A Medical Social Terminology*, Hospital Social Service, March, 1927.

² Stearn, Frances, *The Food Clinic*, Food Facts, September 1927.

Caring for Emergency Cases

By EDWARD F. DEAN, M.D.

University of Colorado School of Medicine, Denver, Colo.

THE city of Denver, Colo., assumes responsibility for the emergency care and treatment of persons injured upon the streets and in public places. Such cases are sent to the Denver General Hospital after being picked up by the police surgeons of the city. The emergency surgical service of this hospital is divided into two parts—cases brought in by the police and emergency cases arising among the patients in the hospital.

We shall begin with the emergency cases brought in from the streets and public places of Denver. Upon the arrival of the ambulance at the gate of the hospital, the gatekeeper, by electric signal, notifies the superintendent's office, the office of the director of nurses, the emergency room and the receiving room. When the ambulance arrives at the receiving room, orderlies are ready with perambulators. The patient is received from the police surgeon or police officers. The admitting clerk makes a record of the name, the address

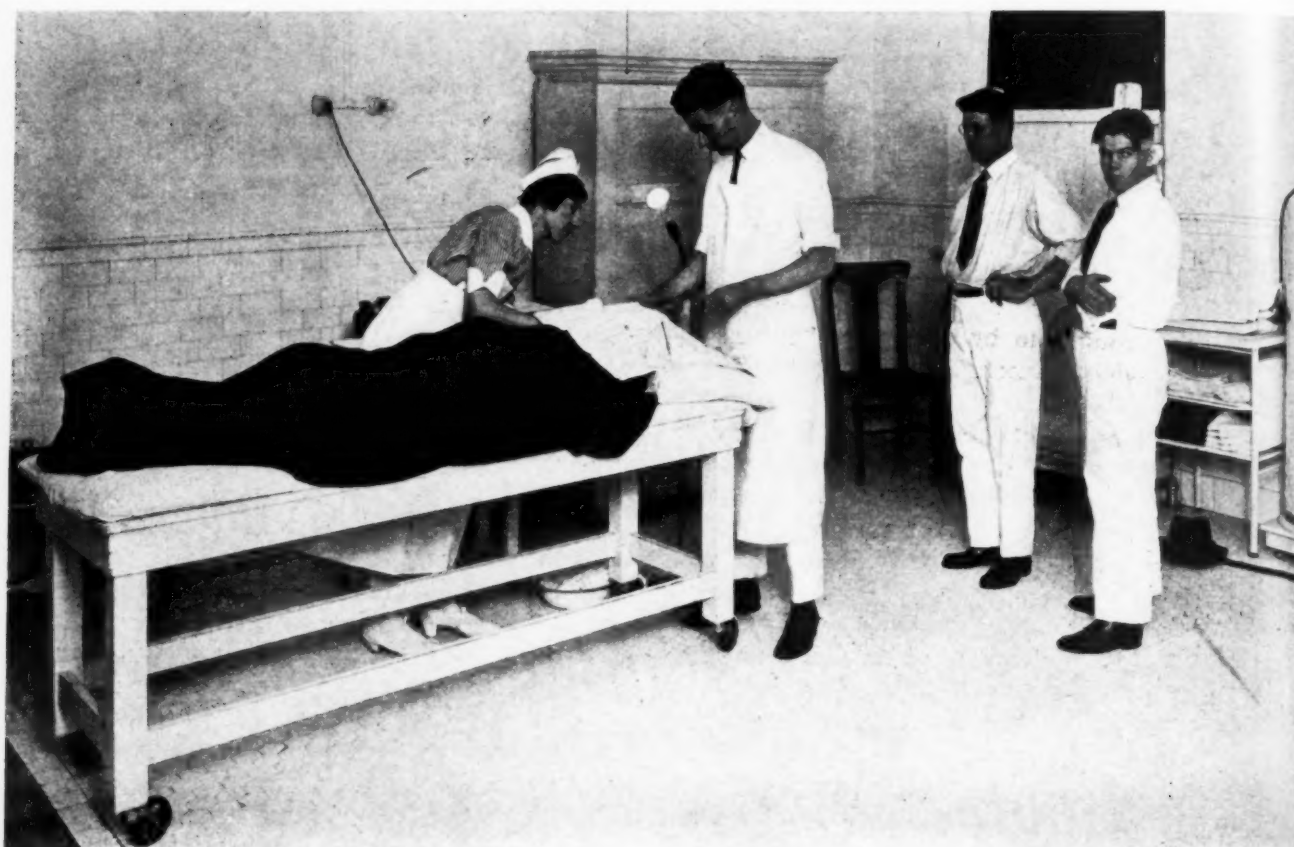
and such information as it is possible to obtain from the officers or from the patient. This is recorded upon the patient's card of admission which bears a permanent number for that patient during his stay in the hospital, as well as his name, the name of the police officer or surgeon arriving with him, the exact time of arrival at the receiving room and the kind of injury. The patient then proceeds to the emergency room.

The number is then copied into a bound book kept in the emergency room, with the name of the patient, the place where the accident happened, the diagnosis, the treatment and the disposition of the case. This information is signed by the attending nurse and the house officer. The book is not removed from the emergency room.

The emergency room is large, well heated, well ventilated and well lighted, with plenty of running water, sterilizers, dressings and instruments. It is in charge of a house officer whose duty it is to give first aid and designate the disposition of the



The laboratory at Denver General Hospital, Denver, Colo.



An accident victim being treated in the emergency ward at Denver General Hospital.

case after examination. The case is disposed of in one of four ways. First, it may be discharged from the hospital as a minor surgical case, after treatment. Second, it may be sent to the x-ray room where a picture of the fracture is taken and the case is discharged from the hospital as a fracture case, the patient receiving a card instructing him to return to the fracture clinic on the following Monday. Third, it may be sent to the operating room, if the patient is seriously injured. After leaving the operating room the patient goes to the recovery room and from the recovery room to the forty-eight-hour ward. From the forty-eight-hour ward he goes to the general surgical ward or to the fire and police ward and is discharged from there. Fourth, if the patient is in a condition of shock he is sent to the shock room and remains there under the care of a trained nurse until his condition is improved, when he is returned either to the operating room or to the forty-eight-hour ward.

When amputation is required there is a consultation between two staff surgeons. Every patient requiring surgery in the hospital signs a permit, which is attached to his chart. Any patient requiring surgery and not in a condition to give permission, because of alcoholism, narcoticism or unconsciousness, receives a permit for surgery,

signed by the superintendent of the hospital, with the understanding that the superintendent will be present at the operation. When immediate surgery is necessary in the case of a minor whose guardian or parents cannot be located, the superintendent again acts in this capacity.

The fracture clinic is maintained by the hospital one day a week for the treatment of fracture cases coming to the hospital during emergency. It is in charge of the staff surgeon and all fracture cases are reviewed each week. Dressings are then changed and physiotherapy or hydrotherapy is advised whenever necessary, and a check of x-ray pictures is made. Patients are discharged from this clinic after satisfactory results have been obtained.

Shock Room Is Well Equipped

The shock room came into more general use after the World War. It is a large, well ventilated, evenly heated room, in charge of a trained nurse and supervised by the house officer in charge of the emergency room. It has accommodations for three patients. The blankets are kept in blanket warmers, heat containers are applied to the beds when necessary and provision is made for cooling apparatus containing serums and vaccines. Solutions for intravenous injections are

kept constantly at the required temperature for immediate use and the room has hot and cold water. It is in a part of the hospital where the room can be kept quiet.

The operating room is ready for emergencies twenty-four hours a day. The recovery room accommodates three to four beds. It has hot and cold water, is well ventilated and the lights are so arranged that the room can be darkened. Every convenience for aiding a patient's recovery from an anesthetic is found in this room and a trained nurse is constantly in charge. All patients leaving the operating room are placed in the recovery room until they are ready for the forty-eight-hour ward. This room likewise is in charge of the emergency room house officer.

How Forty-Eight-Hour Ward Is Used

The forty-eight-hour ward is divided into male and female sections. Patients are received there for treatment after they leave the operating room, the x-ray room or the emergency room, and they remain generally not over forty-eight hours. The nurse's station in this ward is so arranged that the nurse can look into either the male or the female ward. After leaving the forty-eight-hour ward the patients are sent to the general surgical wards or to the fire and police ward.

The city of Denver maintains a ward for members of the fire and police forces who are injured in the line of duty. These patients are received into the hospital through the emergency room and then pass on through the forty-eight-hour ward

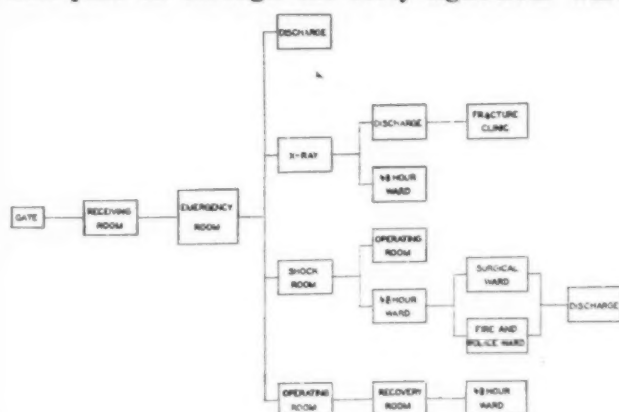


Chart shows routine in handling patients from the time of entrance to the time of discharge.

before going into their own ward. The fire and police ward was set aside by the city council for the use of members of these forces and it is kept ready for emergencies that occur in these departments. This room is in charge of a special nurse. It accommodates twelve beds, has a private bath and a diet kitchen and is operated as an independent part of the hospital. Surgery in this ward is handled by one man and discharge from the hos-

pital comes through the chief resident physician after a recommendation by the surgeon of this department as in all other cases.

The fracture clinic was created several years ago and is in charge of the staff surgeon assisted by the house surgeon. It is held each Monday morning at eight o'clock at the hospital. All fracture cases from the previous week attend this clinic and are treated and their dressings removed when necessary. Instructions are given them regarding their care, food, physiotherapy and hydrotherapy and each one receives a card stating the date when he should return. These cases are treated regularly at this clinic until a final x-ray picture is made and they are discharged. A stenographer is present at each clinic meeting and takes the progress notes for each case. These are added to the chart which is made for the patient when he enters the hospital. At the present time this clinic has an attendance of about thirty-five patients. Fracture cases of all kinds come for examination and treatment. They receive their discharge from this clinic by recommendation of the staff surgeon.

The Denver General Hospital has about 500 beds.

Dealing with 36,000,000 Relatives of Hospital Patients

Consider the lot of the hospital administrator. It is not an easy one. Not only must he look after the welfare of the sick persons who come to his institution to get well, but he must also mollify and pacify and please the relatives of those patients within his institution. He must convince those relatives that the hospital is giving the best of service to its patients and that every facility of the hospital is being used to hasten the recovery of those under its care.

"Where hospitals deal with 12,000,000 patients a year, they also deal with 36,000,000 relatives," according to Paul H. Fesler, superintendent, University of Minnesota Hospitals, Minneapolis, "and hospitals must give a service of satisfaction to the relatives as well as to the patients."

What the Superintendent Can Do for the Occupational Therapist

"What can I, as a superintendent, do for the occupational therapist?" asks Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia. He answers the question in the February issue of *Occupational Therapy and Rehabilitation*.

"I can recognize her, if she deserves to be recognized, as a specialist, a person who is recognized by the personnel of the hospital as one with a special service to give; something she can do better than the average.

"By so doing I will permit her within the 'holy of holies' that surrounds the patient's bed. She will not be a stranger there, because she brings in her basket something more than raffia and yarn—a healing service."

The Hospital Beautiful Is Easy to Achieve by Careful Planning

By EDWARD F. GARESCHÉ, S.J.

Milwaukee, Wis.

BEAUTY in all its phases is easy to recognize, but difficult to define. Few persons there are who do not have some sense of beauty and are not moved and affected by lovely scenes and sounds. One of the most satisfying definitions of beauty is "that which pleases one on being perceived." The esthetic pleasure received on the mere perception of a thing is fundamental to true beauty. Beauty is not synonymous with costliness, or complexity, or elegance, or grandeur. It is in the simple flower, as well as in the intricate work of art. Beauty is in the face of the child and in the hues of the sunset. Nature abounds with beauty and in the work of human hands beauty is a quality achieved by imitating the loveliness of nature.

The hospital beautiful, therefore, does not mean the expensive hospital, the elegant hospital or the hospital that is decorated showily and pretentiously. The quality of beauty comes to a hospital from the skilled and persistent effort to make it beautiful. One hospital may have cost great sums of money; it may be excellent from the technical standpoint, with a supply of modern equipment; it may be constructed of costly materials and yet be displeasing to the eye. So far as beauty is concerned, the rich material is wasted for lack of taste, for want of harmony. Here there may be expensive material and splendor, perhaps the glitter of marble and even the luster of gold, but no beauty.

Beauty Is Inexpensive

Another hospital may be more cheaply built and poorly furnished so far as the cost is concerned, but if it is planned with skillful and loving care, if its proportions are pleasing, its style tasteful and charming, its interior decorations marked by harmony and good taste, then that hospital is beautiful. It is the taste of its planning and decorations rather than their expensiveness that gives it beauty.

But is it worth while to take the trouble to make a hospital beautiful? Translated into other terms, the question amounts to this: "Is it worth while to take the trouble and care to make the

hospital pleasing to the eye, agreeable, appealing, comforting to those who enter it?" From what we know of the influence of the mind over the body, of the therapeutic value of calmness, pleasantness and cheerfulness, there can be no doubt that it is worth while to make a hospital as beautiful as possible, with that manner of beauty that cheers, comforts, elevates, calms and consoles.

First Impressions Are Important

Imagine yourself a patient on whom has fallen the misfortune of sickness, so that you are obliged to go to a hospital. You are leaving your own home, your usual surroundings, and being carried into a place of which you have little knowledge. The impressions made upon you as you go into the hospital are important. You look about to see what sort of a place it is. If you find that the hospital entrance is gloomy and unpleasant, that the vestibule as you passed through it is unharmonious, that your room is bleak and forbidding, your spirit is chilled and displeased. The atmosphere of this forbidding place lowers your vitality and your mind becomes depressed.

But if, as you approach the hospital, you instinctively say to yourself, "What an attractive, harmonious building;" if, when you enter the doors, the combined influences of soft, beautiful colors and harmonious outlines, and an interior of beauty, cheerfulness and charm await you, if flooding light from the sun or from lamps is tempered to a mellow glow, and pictures that please and inspire greet you as you pass, then your spirit is uplifted and you feel cheered, calmed, comforted.

You are tucked away in bed in a room or a ward of the hospital, and as you open your eyes and look out from the pillow you half consciously take in the scene before you. If the hues and tints of the room are beautiful and suited to your mental needs, if the outlines are harmonious, the furnishings tasteful and the pictures, if pictures there be, are works of art, then your whole being is unconsciously illuminated and elevated. The powerful influence such surroundings have upon the

sick, especially those who are supersensitive to external influences, is difficult accurately to calculate. Experiments have been made that are said to show definitely the influence of colors on the physical system. Thus red is a cardiac stimulant, yellow is a nerve stimulant, neutral tints of gray act as a sedative on the nerves.

From these standpoints, therefore, it is surely well worth while to make the hospital beautiful. And what is the cost of beauty? Usually it is not a cost to be measured in terms of money, but rather in terms of skill, care, planning, the deliberate effort after beauty. That subtle thing called "taste," which some persons possess by nature, but which can be developed through training, is necessary to perceive and bring into being the hospital beautiful. The many ugly hospitals that are found scattered far and wide throughout the land are not ugly for want of expensive fittings or costly materials. One thing makes them ugly—the absence of taste.

And there are as many ways of being ugly as there are ways of being beautiful. A hospital may be ugly with the glitter of marble, the heavy luxury of velvet and gildings, or it may be ugly with the bare ugliness of plaster and cement. So, too, it may be beautiful with the beauty of costly and harmonious fabrics and of marble and gold, or it may be beautiful with the chaste simplicity of tinted plaster and inexpensive furnishings chosen with skill.

Every One Appreciates Beauty

It is true that not all those who enter the hospital are affected in the same way by its beauty or lack of beauty. Persons of trained tastes will see at a glance that the hospital is or is not beautiful and tasteful and may even be able to point out just why they are displeased by this and pleased by that. Simpler people will be unable thus to analyze and define their impressions, and to give the reasons for them, but they will be impressed none the less, favorably or otherwise, by the beauty or want of it of the hospital. Beauty appeals to the finer side of human nature and true beauty speaks a universal language. Those whose tastes are uncultivated sometimes mistake what is false and inharmonious for beauty, but they are still responsive to loveliness. The most obtuse and dull patient brought into a hospital, if he is able to observe at all, will probably experience some reaction to the true beauty of the place. Even those who are mentally ill show a marked sense of pleasure in the beautiful and are stimulated or depressed by their surroundings.

The hospital beautiful is a desirable thing not only from the viewpoint of the patient, but also

from the standpoint of the hospital personnel. If the hospital is beautiful its personnel will more than likely be content, proud of their hospital, bright in spirit, cheerful in outlook. To work all day surrounded with ugliness is depressing. To work surrounded on all sides by true beauty is healthful, stimulating and satisfying.

Plan New Units With View to Beauty

How can we make a hospital beautiful? The best time to insure that a hospital shall be beautiful is when it is being planned and before the actual construction begins. Beauty is something that must be added to the other considerations of hospital planning. A beautiful hospital differs from a beautiful temple or a beautiful courthouse, or even a beautiful residence. If the proportions of the hospital are harmonious, if its colors and outline are lovely, if it has an abundance of windows to flood the interior with air and sunshine, if it blends with its surroundings and produces a cheerful, hospitable and pleasing impression, then it is beautiful as far as its exterior proportions and aspect are concerned.

The interior beauty of the hospital depends a great deal upon the proportions of the rooms; the choice of their decorations; the presence everywhere of light, abundant yet not glaring; the presence of pictures and statues, lovely in themselves and suited to their surroundings. To provide all these things in the right proportions requires as much skill and special training as does any other department of hospital planning. The hospital architect should, in this regard, be a true artist, one who loves and understands the beautiful in hospitals and knows how to employ the means that will bring beauty into the hospital. It is his part to see to it that both the exterior and interior planning of the hospital are in accord with the principles of beauty. To his efforts must be added the service of an interior decorator who is also an artist, and who understands the requirements of hospital decoration and the harmonies of form and color especially adapted to hospitals. If he is a true artist, he can achieve beauty. If he lacks artistic taste and skill, he may here and there obtain a few beautiful effects, but his is a haphazard and unsatisfactory achievement. Only trained skill can constantly produce correct and beautiful effects in decoration.

Finally, there is the selection of pictures and statues, of furnishings and ornaments, to make the hospital beautiful. When one considers the numerous works of art easily available in accurate reproductions, one marvels that so many unlovely, inartistic pictures find their way into hospitals and into other places as well. No matter how

large the hospital may be and how various its demands for pictures, no hospital could ever exhaust our great inheritance of pictures both appealing and artistic. Such pictures may be had in hand colored photographic reproductions in almost any size, and if these colored photographs are purchased from European firms, they can be bought at a surprisingly low rate. Statues are much more expensive and it is much better not to have any statues than to tolerate mediocre ones in the hospital. It is better to buy a few beautiful statues than to get a number that are inartistic.

In selecting the furniture of the hospital, beauty has to be sought after and planned for. In the Middle Ages, when craftsmanship often went hand in hand with artistic talent, objects of common use were beautiful as well as practical. In the Museum Cluny, Paris, one may see many such objects which the craftsmen of the Middle Ages made lovely out of pure joy in, and devotion to their work. Modern efficiency in manufacturing often goes hand in hand with ugliness, but this is no reason for excluding beauty in things useful. In choosing furnishings for the hospital a definite demand should be made for beautiful things, for furniture whose outlines are graceful and pleasing, whose color scheme is restful. Beauty is that which pleases by merely being seen, and there is no reason why the furniture of a room should not be useful and at the same time possess this quality of beauty.

New Units Should Harmonize With Old

All these suggestions are, of course, more easy of accomplishment when a hospital is to be built, when it is being planned from the very beginning and all the details that bring beauty, whether of construction, adornment, or furnishings, may be modified as one wishes. Yet, even the hospital that is already built should be studied by experts so that it may become more and more beautiful, or at least less and less unpleasing. The additions that are put on hospitals almost always either make them more beautiful or take from them some of the beauty they may have had before. Harmony in architecture between the addition and the original building, the avoidance of abrupt changes of style, the using of similar or of harmonious materials—these things all help to make the hospital more beautiful.

The exterior of a building may sometimes be much improved by changes in the outline or adornment which are relatively inexpensive, but are well worth while from the standpoint of beauty.

It is in the interior of the hospital, however, that good taste can do most, even after the hospi-

tal is already built and furnished and decorated. Sometimes the interior beauty of the hospital is greatly helped by clearing away superfluous ornaments, by taking out pictures and statues that are unsightly. An excess of adornment is often more harmful than too little, from the standpoint of beauty, and it is better not to have ornaments at all than to have them tawdry and untasteful. When new furnishings are to be bought, good taste is a necessity in the buyer. When rooms have to be redecorated or new pictures provided, if the hospital executive either has artistic ability himself or the wisdom to secure the services of one trained along these lines, beauty may be brought into the hospital with little or no additional cost.

Should the Medical Teacher Sacrifice His Practice?

The part-time medical instructor, according to an article appearing in a recent issue of the *Medical Standard*, generally is a more capable instructor in modern medicine than the one who devotes his whole time to teaching at the sacrifice of a practice. The reasons for this are evident, in that the doctor who is in general practice will be continually confronted by new problems, and through these problems will continue to broaden his knowledge of medicine, whereas the man who has no practice will limit his learning to books, and possibly to special cases which are brought to his attention by other members of the profession.

The instructor whose knowledge is thus limited by lack of contacts with current problems and progressive study in his field, will not be able to stimulate creative thought and, in the practice of medicine or surgery, it is untenable to hold that the true teacher is only he whose practice is limited to his research laboratories and the comparatively few beds allotted to him in a teaching hospital.

The writer of the above mentioned article states that: "For the part-time teacher one cannot but hold a strong brief. His outside contacts with the actual practice of medicine help to keep his feet on the ground and he treads a safe pathway. His teachings will reflect both his research spirit and the lessons of practice. He will prove a stimulus to his students, his colleagues and the profession at large; his patients will benefit by his research and his research will be more wisely directed."

Day of Hospital Scrub-Woman Is Waning

The hospital scrub-woman will soon go the way of the washboard and the old-fashioned sadiron, believes Dr. Warren P. Morrill, superintendent, Columbia Hospital for Women, Washington, D. C., who has found that the cost of using the floor cleaning machine is 40 per cent less than the cost of cleaning floors by hand. With the attachments that come with a good floor cleaning machine, terrazzo, linoleum, composition and wood floors are both scrubbed and polished, and in far less time than is consumed by hand scrubbing.

STUDIES ON HOSPITAL PROCEDURES

Training School Relationships

IN THE March issue of THE MODERN HOSPITAL, there appeared a description of some of the relationships existing between the school for nurses and the hospital. Perhaps it would be more accurate to indicate here that the training school for nurses is, and should be considered, under ordinary circumstances, an integral part of the hospital. The article therefore sought only to portray the relations existing between the hospital and one of its major departments.

It was stated that the superintendent of nurses should, and must have full control over the graduate nurses performing private duty work within the institution. Herein lies a possibility for not a little misunderstanding if not actual friction. The graduate nurse frequently feels that her sole obligation is to her patient through the physician who usually engages her. She is likely to be irritated when the directress of the school for nurses requires strict adherence to the technical and general rules of conduct set down for the guidance of nurses in the employ of the institution.

Directress Is Enforcement Officer

Wherever a registry is conducted, the graduate nurse is inclined to question the wisdom of some of its regulations. She finds it difficult to understand why she is required to comply with rules covering twenty-four hour duty nursing in certain types of cases, and those which force her to accept all types of patients no matter what her individual inclinations may be. True it is that the physician is her only superior officer when it comes to the actual treatment of the patient, but just as the doctor is permitted to practice within the institution provided he adheres to its rules and regulations, so is the nurse granted the right to practice her profession under like conditions.

Disobedience to rules that require prompt reporting for duty, rules that forbid the graduate nurse to leave the hospital except for definite recreational hours, must be promptly and courageously met. Moreover, the enforcement officer is none other than the directress of nurses. The

physician can be a great source of good in helping to elevate and maintain the morale of the hospital at a high level by discouraging any infractions of rules by graduate nurses under his medical direction. Gossiping and willful idling of time by graduate nurses whose patients do not require constant attendance should be discouraged, and boisterous conduct in and about the corridors and locker rooms maintained for graduate nurses should be frowned upon.

The fact that the members of a patient's family are paying the fee of a graduate nurse in no way permits her to depart from the adherence to rules under which intrahospital nurses work and live.

Functions of Schools for Nurses

The second part of the article deals with the organization and management of the school itself. There are persons who believe that a school for nurses does not belong within the hospital, that its board of trustees has no right to expend for educational purposes money that has been contributed for the care of the sick. There are members of the medical profession who freely state that the nurse receives too much education and that her course should be more practical. There are others who contend that the nurse is granted too few educational advantages and that she is required to perform excessive manual labor of a noneducational and hence of an unprofitable nature.

These matters, largely controversial in nature, will not be fully discussed here. An attempt, however, will be made to present in as practical a manner as possible some of the basic facts relative to the functioning of schools for nurses in both large and small hospitals. Comment will also be made upon the economics of conducting a centralized teaching effort for nurses as well as upon the general principles involved in university and training school relationships.

The question has not yet been fully answered as to when a hospital has attained a size and opulence to warrant the inauguration of a school for nurses. There must be of course an ample amount of clinical material for the education of the pupil nurse. There must be ample funds available so that the proper educational atmosphere can be created and maintained. That schools for nurses are sometimes conducted as a money saving effort is mentioned only to condemn such a practice.

Since 1861, the number of schools for nurses has grown until there are now more than 2,000 in this country. Most of these schools are connected with hospitals. Many of them are inadequately equipped, and there is to be found too frequently, a lack of educational vision and a cer-

tain pedagogic blindness, disastrous to any educational venture.

The physical equipment of the school for nurses is of two kinds. First of all, it must consist of proper facilities for the comfortable housing of students. These should approach in nature a well conducted boarding school for young women. Second, there must be facilities necessary to provide for the student's educational needs. Concerning housing provisions, instead of representing a happy medium between extravagance and squalor, they are more likely to be either too luxurious or too frugal in nature. There can be no question about the fact that to provide too handsomely for the pupil nurse is to predispose to a certain unrest—a dissatisfaction with her living conditions after graduation. To provide inadequately for the nurse's comforts is to detract from the proper care of the patient.

The home for nurses should certainly be located at a sufficient distance from the hospital wards, so that neither the patient nor the nurse will be disturbed by the activities of the other. Relative to such questions as the proper size of nurses' rooms, the number of toilets and wash basins that should be provided for a given group, the location of the dining room within the home or elsewhere and the cubic footage necessary to construct a building for housing graduate and student nurses, it is not necessary to enter into a detailed description of these matters since their solution is often governed by local circumstances in no way common to the field. Current and past hospital literature contains full discussions of these subjects.

Making a "Home" for the Nurses

It may be said, however, that the nurses' home should represent everything the name implies and that it is preferable to meet all the requirements of the nurse within its confines. This refers particularly to the advisability, all things being equal, of constructing dining room facilities within the nurses' home if funds are in any way available, and of rendering every aspect of the nurse's life as pleasant as possible.

In some large institutions, it has been found practicable to construct a distinct educational building within which are to be found classrooms, laboratories and all the requisites of a modern nursing school. In other localities, the first floor of the nurses' home is largely given up to classrooms, laboratories, library and recreational facilities. Such provisions are commonly absent, and it is regrettable to find in some hospitals so little physical equipment for the teaching of nurses, and to observe that classrooms and laboratories are frequently below ground. When a hospital

finds itself unable to meet the obligation it assumes in admitting young women for the study of nursing, only two alternatives remain—either to discontinue the school for nurses and to employ graduates, or else to seek an avenue of escape such as affiliation with a university or some other organized educational effort that offers the courses required by the nursing curriculum.

There has been, and no doubt will be much discussion relative to the advisability of conducting a nursing course in conjunction with a university. In several recognized educational institutions of the country is to be found a definite integration of the nursing course with that of other courses offered. This is true at the Universities of Minnesota, Indiana, Georgia, Cincinnati, Stanford, California and Iowa. Columbia University and Simmons College, Boston, have modified courses in affiliation with a hospital school.

Relation of Hospital and University

It has been stated, however, that in order to carry forward in conjunction with a university the work of educating a nurse, the control of the hospital should be entirely in the hands of the faculty of such an educational institution. It has been found unsatisfactory simply to send nurses to classes and have them return later in the day for their practical work in the hospital. Those best informed believe that a student nurse should matriculate as do the other students in the university, and that her courses should be as thorough and as carefully worked out as those leading to academic degrees. The difficulty arises in arranging for the absence of a nurse from the hospital while she is attending classes, since the care of patients cannot be interrupted by any other demand no matter how pressing.

The ratio of one theory hour to ten hours of practice, as carried out in many hospitals, is probably insufficient to a well rounded course of nursing instruction. University authorities are almost unanimous in demanding more theory and less practice, and leaders in nursing are clamoring for a reduction in the routine and manual work of the nurse's everyday life. It is a fine and easily substantiated theory that it is advantageous to a student nurse to receive an academic degree at the end of the course that has given her instruction in both a university and a hospital.

The question, however, that remains to be answered from the standpoint of the hospital administrator is: How, in the majority of institutions hampered as they are by the lack of funds, can the patient receive his baths and medication when the nurse is busily employed in carrying out experiments in the laboratory or in taking notes

in the classroom? To employ a large number of graduate nurses who will actually perform bedside nursing while the pupil is educationally occupied elsewhere is impossible for most hospitals. There can be but little doubt that teaching by trained educators with ample time and material at hand will, in the majority of instances, far surpass that available in most hospitals. The deplorable fact, evident to many, is that much of the classroom instruction that the pupil nurse receives emanates from assistants or associates on the medical staff and not from the chiefs, and that frequently the lectures are poorly prepared and illogically delivered.

Inadequate Instruction Often the Rule

It is often felt that the student nurse, ignorant as she is of the art and science of nursing and medicine, is fortunate if she receives from the medical staff, lectures of any type. This lack of teaching ability on the part of many physicians selected for the delivering of nursing lectures has led to the suggestion that at least the preliminary courses in the curriculum should be given without the hospital and that an attempt should be made to centralize this effort insofar as several schools are concerned. Theoretically this procedure is sound and leads to an improved type of teaching. On the other hand, it is expensive. In one city in the East in which such an effort is being successfully carried out, the expense to the hospital is \$60 per nurse for tuition plus a considerable outlay for carfare.

Because universities are often unavailable or else offer no facilities for practical affiliation with schools for nurses, and because of the expense of carrying out a centralized educational effort, inadequate instruction is the rule rather than the exception in many localities.

It will be noted that no attempt has been made to state when a hospital should conduct a school for nurses. It is easier, in the light of standardized requirements of state boards and national nursing bodies, to state when it should not.

The organization of the school for nurses is usually headed by a well trained woman who is a graduate in nursing and who has demonstrated sufficient executive ability to indicate that she is capable of meeting the exacting requirements of such a position. A job analysis of the duties covering this position, finds no place or possibility in this article.

It may be stated, however, that in the small school, the directress is the executive, teacher, truant officer and mother for the nurses and the administrative assistant to the superintendent of the hospital. In the large school her duties are

perhaps less complicated but no less difficult. Here one finds assistant directresses, an educational director with one or more assistants and an organization that consists of the ward supervisors who are performing not only the supervision of actual bedside nursing but who also are engaged in distinct teaching activities.

The supervision of the home life of the nurse requires matrons, social directors, dietitians and a physician who must assume the responsibility of protecting the health of the school. The presidency of an academic school with from 200 to 500 students is an exacting position. But to these duties, in the case of a superintendent of nurses, are added many others of a professional nature that require both training and tact.

The liaison that must exist between the work of the educational director and the practical exemplification of the principles that she teaches in the wards must be a close one. How frequent it is to find good theory being taught in our schools, and the shabbiest of practices permitted. There is no more disconcerting experience than that which confronts the student nurse in explaining to herself the reasons for this occurrence.

There are always some inter-relationships existing between the duties of individuals employed both in contributing to the welfare of the patients and to that of nurses. The hospital dietitian, for example, is expected to plan meals for the sick and at the same time to make her contribution toward providing balanced menus for the nurses. It is difficult to say what proportion of her time should be given to either activity. She is tempted sometimes, because of frequent complaints relative to inadequacies in nursing menus, to devote more time to this work than she should and by so doing to slight the menus of patients.

No Parallel Lines of Authority

Too often is the assumption made that irrespective of the exacting duties of the dietitian in the hospital, the nurse must experience no inadequacy in either diet or housing. It is true that she should have the best, but if there is a superlative degree to this quality, it should be made truly descriptive of the facilities and food given to the patient.

In passing it may be said that there should be no parallel lines of authority within the school for nurses. All such lines should converge at the desk of the directress, and should proceed from there to that of the superintendent of the hospital. In the university plan too frequently it is found that the superintendent of nurses is responsible not to the administrator of the hospital but to the dean of the medical school or to some

other officer. This faulty organization explains the friction too often observed under the above circumstances and always to be expected when unsound organization principles are adopted.

Some comment has been made concerning the necessity for ample funds in properly conducting a school for nurses. The budget is rightfully a burning question in the minds of superintendents of training schools. Growing deficits are even more a source of concern to the hospital administrator. It is certainly the responsibility of the trustees of the hospital to provide funds for the proper functioning of the school for nurses. For a hospital administrator to permit a training school to be throttled financially while any project in which he is more interested flourishes, is devastating to both the morale of the hospital and to his own administrative peace of mind.

Cost of Educating the Nurse

Much work has been done in endeavoring to learn how much it costs to educate a nurse. The aim of these studies has been to make more practicable the adoption of a separate budget for the school for nurses. If this were more often possible, there would be less friction than is now unfortunately the case between hospital administrators and the heads of nursing departments. As the pressure for higher educational standards has increased, thoughtful administrators are more often asking themselves the question: Who will nurse the patients if working days for student nurses become shorter and educational requirements, more exacting? It would be fine indeed if an ample graduate staff were always available to relieve student nurses at class time. When a budget for the nursing of hospital patients is being prepared, this question immediately presses for solution.

A committee appointed by a national nursing association a few years ago circularized the field in an effort to learn the opinion of hospital and nursing executives in regard to the advisability of a separate budget for training schools, as well as to ascertain what sum should be set aside for the housing and education of the individual nurse. An attempt was made at that time to learn the amount of capital investment required for housing each nurse as well as the outlay necessary for providing educational advantages. It was computed that each student nurse cost the hospital in which she was working about \$1,300 a year and that the average expense for the services and maintenance of each graduate nurse was \$1,800 for a like period. About one-third of the total expense for the student nurse was required for educational and special purposes.

This committee, after a somewhat complicated calculation in which relative percentages of efficiency of the pupil nurse and the graduate nurse were considered, arrived at the conclusion that the cost of the services of the student nurse an hour was fifty-four cents, and that the hospital lost approximately \$125 dollars a month for each student nurse in the school.

One would conclude that if these statistics can be taken at their face value it would be cheaper to employ graduate nurses for the care of the sick. Practically, it must be remembered that many institutions are inadequately conducting their schools, and that because of this fact they are securing care for their patients at a rate less than that necessary to employ graduates. All of which seems to indicate, in spite of the confusion existing in the minds of nurse educators and hospital administrators, that to educate the student nurse properly, and at the same time to care for the patient, requires a much greater outlay for graduate nursing than is usually found available in the average hospital.

There seems to be a decided trend toward assigning a separate budget to the hospital training schools throughout the country. Indeed in most institutions there is to be found an attempt at least to draw up budgets providing for the work of most of the major hospital departments. In order to have any budget operative, however, there must be a greater manifestation of business ability on the part of those supervising its functioning than is sometimes seen. There are some practical problems that present themselves in this respect.

How to Obviate Misunderstandings

It would be better, no doubt, for funds for a separate mechanical force for the nurses' home to be budgeted in our hospitals so that demands for immediate repairs therein might be promptly met without detracting from the hospital itself. It is frequently found that where not enough supplies are available in either the nurses' home or hospital, misunderstandings arise when the former need is not promptly met. In other words, should hospital repairs be delayed in order that nurses' home repairs might be quickly made? This is the rock upon which not a few administrators and directresses of nurses have split.

The purchase of teaching supplies, books, uniforms and other essentials is of the greatest urgency and necessity. But when funds are not available for the payment of bills for gauze and food and coal, the latter is usually given precedence over the former.

It is from such situations as this that the de-

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mands for a separate training school budget have originated. It is not necessary to discuss further the details of the training school budget. The principles underlying its need and functioning are matters of far greater importance. THE MODERN HOSPITAL favors, under propitious circumstances, the attempt definitely to budget this activity, and this having been done, to hold the training school executive to a strict adherence of its provisions.

The curriculum of the school for nurses is more or less governed in most localities by state board requirements. True it is that in the minds of many visiting physicians there is much doubt as to why psychology, chemistry, bacteriology, ethics and similar subjects are necessary to the nurse. In many schools, the minimum state board requirements only are met in their curricula. The difficulties that arise are not so much in the subjects to be taught as in the securing of willing and competent instructors and of arranging hours for their lectures. The school should select the hours most convenient to itself rather than to allow its instructors to do so. It is most questionable whether evening hours are necessary or in any way fair to the nurse. Classes in the morning usually interfere with the work of the hospital and, after all, the demands of the patient must come first.

Doing Away With Class Distinctions

The hope for the maintenance of any profession on a high level rests in the younger generations of those who practice it. The teaching of ethics, of obedience to those in authority, of the avoidance of a spirit of militarism, are matters which, if given adequate attention in the nurse's undergraduate days, will bear fruit later on.

The schools of nursing, therefore, have the future of nursing in their hands. Hence the need for the careful selection of superintendents. Much has been said concerning the actual organization and policies of the school for nurses but little concerning the novitiate in the profession, the probationer. How she is secured and what her preliminary education shall be are matters that might consume many papers. There is one thing, however, that distresses those who view for the first time the life of the pupil nurse. A certain unhealthy class distinction largely predicated upon the color of uniforms, the cut of caps and the length of experience is too often manifested. No training school spirit is finer than that truly democratic in its make-up, the graduates being in fact, as well as in name, "big sisters" of the newcomers.

The medical care of the members of the student body is of the greatest importance. Vaccination

against typhoid and smallpox, frequent physical examinations, underweight and overweight tables in the dining room, provisions for proper social recreation, are all matters requiring careful thought on the part of hospital and training school authorities. To this end, it has been found advisable in many schools for the service of a physician to be almost wholly directed toward the exemplification of the practices of preventive medicine in the student group. Careful selection of applicants from a physical as well as a mental standard and the protection of their health after their entrance to the school are money saving as well as humane practices on the part of the hospital.

Elevating Standards of Health Through the Rural Hospital

The rural hospital program, according to the tenth annual report of the Commonwealth Fund, New York City, is an experiment in social organization involving much more than a building project. It is an effort to attack from a fresh angle the difficult problem of medical and public health service in small towns and the open country and to change community standards in respect to the care of the sick, the prevention of disease and the protection of health.

Typical of the general program is the work now going on in the district of nine Virginia counties served by the Farmville Hospital. The state health department has organized this territory into a single unit with a district health officer, under whose leadership a comprehensive health service is being gradually developed. Two medical institutes have been held, with clinical demonstrations and lectures on chosen topics. Ten local physicians have been awarded fellowships for brief postgraduate courses at well known medical centers. The hospital itself is proving its usefulness to the community and has been operated under the direction of the local board of trustees on a gratifyingly high standard.

Hospitals Profit by Cooperation With Health Departments

In a recent issue of the *Hospital, Medical and Nursing World* an editorial tells of the ways in which many hospitals and health departments have found it profitable to cooperate. Some health departments purchase laboratory service from local hospitals and similarly many hospitals that cannot afford to establish and maintain a complete laboratory of their own, find it satisfactory to purchase this service from the local health department. Many state health departments are used fairly extensively by both hospitals and local health departments.

Certain general hospitals are beginning to help out health departments by receiving patients suffering from communicable diseases. This is an economy for the departments concerned and at the same time provides a better service in the hospital. Such an extension of general hospital work gives a broader service to interns and nurses, and in some cases the hospitals receive money from the community chest for this service.

Editorials

The First International Hospital Congress

IT IS with a peculiar feeling of pride that THE MODERN HOSPITAL views the approach of the first international hospital congress. Suggested in these columns less than three years ago, the project at once attracted the interest and imagination of the whole hospital field both here and abroad.

The American Hospital Association is to be commended for so promptly and effectively translating the idea into an actuality. That the suggestion fell on fertile European soil is attested by the prompt response of a dozen countries when asked to send delegates to the two Paris conferences at which the groundwork for the coming congress was laid. From England, Italy, Switzerland, Holland and Czechoslovakia, Mexico, Belgium, Hungary, Sweden and America they came. And France played well the part of the courteous host.

It is America and her hospital workers who will be privileged to demonstrate their ability as hosts to the visiting delegates from abroad. To the international hospital committee, which consists of two representatives from each country, there is presented an opportunity to accomplish a lasting good for hospital work everywhere. It will be enjoyable and not a little profitable for the American hospital group to meet and discuss common problems with those from other countries. The bonds of professionalism will be strengthened and lasting personal friendships formed. The scientific presentations will no doubt be carefully prepared and interestingly presented, if one may judge from the caliber of the distinguished participants whose names have been mentioned.

But the idea of internationalism in hospital work must not die with the echoes of the speakers' voices. If this should come to pass the justification for the expense and effort necessary to conduct successfully a venture of such magnitude might be in doubt. From this first international congress there should arise a great stimulus toward the formation of national hospital organizations in each country participating. To accomplish this will require much intelligence and more tact and organizing ability, since the administration of many European institutions is directed by the state or by other governmental or religious bodies. As a logical sequence of this step a perma-

nent international hospital association might easily follow.

There are those who disfavor such an attempt. But certainly were such an organization possible, and THE MODERN HOSPITAL predicts its existence in the near future, the standardization of hospital practices and organization and even the consideration of such matters as the adoption of a better nomenclature denominating disease states, or the search for standard methods of computing per capita costs, might be successfully accomplished.

The joining of a greater and more varied administrative experience as represented by the opinions of American and European executives would give a more valuable cross section from which to judge concerning the solution of many such problems. A permanent secretary here or abroad would be a constant source of information and encouragement to the field generally. The scope of hospital work is as wide as the world, and the patients for whom the hospital exists have similar needs no matter from what country or clime they come.

The thirty-first convention of the American Hospital Association should be long remembered as one characterized by the presence of interesting hospital workers from abroad and for instructive and stimulating scientific presentations. Let this association not falter in preparing a program and entertainment worthy of the occasion.

When Is a Hospital Full?

THE basis of all occupancy statistics must rest on the actual or estimated capacity of the nation's hospitals. That there is much of the indefinite in the total bed census, which represents the institution's maximum capacity, becomes at once apparent to anyone who seriously endeavors to compute accurately the percentage of days during which a hospital renders its full service to the community.

Most institutions have a more or less mythical figure that represents their size in beds. In arriving at this figure some count bassinets; many do not. Others compute the number of actual beds and cribs in ward or storeroom, and announce this number as their bed capacity.

The municipal hospital's capacity is limited only by its supply of beds and the area of floor space in wards or corridors. Some executives allow a definite cubic footage of air space for each bed, and compute, with this figure as a divisor and the total area as a dividend, the actual institutional bed capacity.

Nor is there any agreement as to the air or floor space necessary to the hospital patient. This

is an angle of the problem that challenges the attention of some body of informed and interested persons.

Capacity and hence occupancy statistics as now estimated and compiled are often grossly inaccurate and sometimes definitely misleading. No one knows with any degree of accuracy what the nation's actual hospital resources are, because there are no standards for computing the capacity of the individual hospitals, and the systems in vogue for the compilation of gross hospital days are so varied as to make even per capita costs approach the value of mere estimates. In some instances, a hospital day represents a full twenty-four hours of service. In others, a day is counted if the patient is put to bed for an hour, receives no food and incurs no other major expense.

It requires therefore but little thought to arrive at the conclusion that any statistical statement regarding cost per patient for any service rendered by hospitals generally, fails to command respect, because of the probability that it is not in accordance with fact.

THE MODERN HOSPITAL commends this subject as worthy of the attention of some committee of the American Hospital Association.

To Merge or Not to Merge?

IT IS becoming more and more evident that the hospital of to-day will not be allowed to exist as an isolated entity in the health program of the community.

The community chest, which is everywhere becoming more popular, is a reflection of a growing conviction that there is no religious, political or even sectional resource wholly responsible for the proper conduct of the hospital. Business men's associations and chambers of commerce are inquiring whether deficits are necessary to the care of the sick. Communities are asking for health and hospital surveys to determine the nature and scope of their obligation to the sick and the poor, as well as to learn how adequately this obligation is being met.

The death knell of the small proprietary hospital is sounding throughout the land. It is a pleasant sound, a heartening dirge for numerous communities and many present and future patients. There are many struggling institutions that have never had any valid reason for existence, or at least have been brushed aside by the onward rush of progress in medical practice. There are others that are but worn-out tools of some physician's vain ambition for professional success.

Such institutions, annually facing a deficit of

discouraging proportions, with inadequate plant and inadequate personnel, must sooner or later yield to the pressure of financial needs or of public opinion and close their doors or seek a merger with other and more prosperous hospitals near by. In such institutions, what should represent a community asset becomes a liability. Struggling board members because of pride or of sentimental regard for family tradition, doggedly continue to endeavor to make financial ends meet, to no avail.

Where such hospitals exist, to merge may mean satisfactory service to the sick and a lifting of the gloom that the annual deficit brings. To merge or not to merge? If this question is answered in the affirmative the problem of the existence of the institution is often solved.

To survey the situation, to translate the findings into action and to pool all community health assets in order to create a strong organization for the common good, is a sane course of action.

Joseph Goldberger—Hero and Scientist

THE life of Joseph Goldberger, so untimely deceased at Washington recently, exemplifies the theory that America is the land of opportunity.

Born in Austria, brought to America at the age of seven years, educated in the public schools and the college of the City of New York, he rose to be one of the world's foremost scientists and one of the greatest benefactors of the human race of this or any other age.

A big man physically, mentally and of soul; a lover of truth; a man of courage, of indefatigable industry, of supreme devotion to duty and of tremendous tenacity of purpose, he entered the United States Public Health Service in 1899, at the age of twenty-five, and suffered from yellow fever, typhus fever and several other diseases in the line of duty. It was not long before the clear, incisive quality of his scientific mind became apparent and he was dedicated to research work.

There is no need to tell the hospital world what he accomplished and how epoch-making were his pellagra studies. Every day we use the scientific truths that he discovered and enunciated with great clarity. He was mentally honest, almost to a fault, as will be illustrated by the following anecdote:

He observed that beans constituted a prophylactic and curative agent for pellagra and so reported. Subsequently, his experiments on animals seemed to prove that his first observation had not been accurate. He immediately published a retraction of his first statement. Later experiments

with animals showed that the only reason that beans had not proved of value with animals was the fact that they were given insufficient doses and that his original observation had been correct. He immediately published a retraction of his retraction.

The death of Joseph Goldberger constitutes an incalculable loss to humanity and to the U. S. Public Health Service, and THE MODERN HOSPITAL voices the sentiments of the hospital world when it extends to his family and his colleagues its sincerest sympathy and condolences.

Talking It Over

THREE hundred and fifty-one years ago, on April 1, William Harvey, the discoverer of the circulation of the blood, was born. For those days, he was well educated and at the age of twenty he entered the famous school at Padua. There he was taught by Fabricius, one of the anatomists to whom the discovery of the valves of the veins is attributed. Returning to London, he was made a Fellow of the Royal College of Physicians and assistant physician at St. Bartholomew's Hospital, the parent of all English-speaking hospitals. As early as 1619, he taught his pupils the circulation of the blood but he did not publish the results of his researches until 1628. While other anatomists had in all probability sensed the fact that the arteries carry blood instead of air as taught by the ancients, Harvey deserves the credit of placing on a sound scientific basis our knowledge of the circulatory movement of the blood.

THE following is a little picture of what happened in the preanesthetic days: On an open field at the battle of Waterloo a surgeon named John Gunning amputated Lord Raglan's arm. The patient bore the operation with silent fortitude, and at its completion shouted, "Hello, don't carry away that arm till I have taken off my ring!" Nowadays, people want an anesthetic for a furunculotomy.

A GOLF player may tee up properly, get a good stance, do a nice waggle, come back properly, hit the ball cleanly but if he doesn't follow through, he doesn't get a good drive. This follow-through is the all important prerequisite of administration. This is just another way of saying that the administrator must check up performance against orders and make sure that he is being obeyed promptly, thoroughly and intelligently. It is easy enough to sit in a swivel chair and give orders—any moron can do it and unfortunately a good many do—but it takes intelligence and initiative to follow through and, without befogging the administrative horizon with petty details, to make sure that policies are being carried out. First of all, an order should never be issued unless it is absolutely necessary, since to issue useless orders destroys alike the authority of the administrator and the initiative of the subordinate. Next, having given an order, the administrator should never forget it until he has checked up to find out if he has been obeyed. This can be done unobtrusively and tactfully but it must be done. The effect on the organization of such a policy is splendid. It learns that once an order is issued, the administrative authority

will pursue it inexorably until it has been obeyed. This one policy will do more in the prevention of slipshod, haphazard ways in the hospital than any other administrative policy.

THE Superintendent told the Chief Nurse,
And the Chief Nurse told the Assistant Chief Nurse,
And the Assistant Chief Nurse told the Head Nurse,
And the Head Nurse told the Charge Nurse,
And the Charge Nurse told the Student Nurse,
And the Student Nurse told the Probationer,
And the Probationer speedily forgot it.
And the Superintendent, the Chief Nurse,
The Assistant Chief Nurse, the Head Nurse,
The Charge Nurse and the Student Nurse
All thought it had been done
And none of them ever knew the difference,
Because like the Probationer
They speedily forgot it and failed to follow through.

IN EVERY business there are two elements that promote continued success. These are good will and trade mark. Good will is the kindly, friendly feeling that the organization has been able to develop and maintain in its clientele; it is the intangible asset that brings tangible returns; it is the reputation for honesty, fair dealing and the willingness to serve beyond the immediate need. Trade mark is the label with which the institution's goods are marked. People buy goods by label and without a good trade mark it is exceedingly difficult to sell even the highest grade product.

HOSPITALS should develop the good will and trade mark idea. The hospital that has the reputation of being gentle, kindly, sympathetic and fair is the one that will be able to do the most good in the community. The hospital should develop a trade mark of some sort, which should be put on all its stationery and on all its publications. It should be used to mark its linen, its ambulances and all other property that the public sees. This good will and trade mark idea should go deeper into the organization than this. Every individual employed in a hospital should endeavor to develop good will for himself. This means industry, gentleness, intelligence, tact and sympathy, and the trade mark they should adopt is that of the good Samaritan.

IT IS estimated that about nine-tenths of the traffic accidents in cities are the result of failure to obey the traffic regulations and we know how disastrous to life, limb and property this disobedience is. All of us deplore this state of affairs and probably do all that we can to drive sanely ourselves. How many, though, have ever stopped to think that these regulations apply to ambulances also? Ambulances are given the right of way and are allowed to break the speed limits but how often is it necessary that they avail themselves of these privileges? Nine times out of ten when an ambulance goes clanging down the street at top speed, there isn't a bit of necessity for hurry and it wouldn't make a particle of difference to the patient if the ambulance got there an hour later. It is most important that hospital chauffeurs get the idea into their heads firmly that they are to set a good example in obedience to the traffic regulations and when this is done there will be many less bills to pay for ambulance repairs.

YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent

[No attempt has been made to offer final conclusions relative to the questions considered in this department. THE MODERN HOSPITAL will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

Who Pays for Special Nursing When Pupil Nurses Become Ill?

Several systems are in vogue for the treatment of student nurses. When an illness is of sufficient gravity to require special nursing, the decision as to this need must always rest with the physician in charge. Sometimes he is a member of the visiting staff. Again some resident physician may offer his assistance in these cases, calling for consultation from the staff when he deems it necessary. When a physician requires the services of a special nurse, a graduate on duty and in the pay of the hospital may be assigned. Such nursing is adequate and is usually less expensive than hiring graduate nurses from outside the institution. Sometimes the directress of nurses assigns a senior pupil nurse to "special" such cases. This type of nursing is almost equally as adequate, and is always less expensive to the hospital. It must not be forgotten that, should the latter system be adopted, the experience gained by the senior pupil in nursing one of her own classmates must be consonant with that detailed in the training school curriculum. Expediency must not be the watchword in nursing education.

Again, administrators sometimes engage a special nurse from the hospital's roster and pay her for her services at the standard rate. When illnesses are of any extent, a considerable bill is incurred. However, the hospital's obligation for the adequate treatment of sick nurses is such that, if student or graduate nursing is not available from within the hospital, proper care must be secured at any cost. In fairness to the hospital, however, it may be said that graduate nursing should be discontinued at the earliest possible moment and a less intense grade of care supplied by floor graduates or student nurses.

What Shall Be the Privileges of Visiting Physicians When Off Duty?

Often when a staff member retires at the end of his tour of duty, he is allowed by his successor to refer cases to the ward and to assume full control of their treatment. This is, in principle at least, an act of professional courtesy that should be encouraged. On the other hand, a distinct injustice to the physician on duty can be done if too many of these cases are admitted. It would be possible for a skilled and popular physician actually to bring about a condition whereby the physician

would be on duty only nominally. Except in rare instances, it would seem that these cases desiring entry into the ward of a hospital should be referred to the physician on duty, and that the doctor who has just retired from service should be off duty in fact as well as in name. In the surgical department, this arrangement of permitting the physician off duty the courtesy of the ward of his colleague, is often of more practical advantage to both patient and physician than in the other departments. A patient, having confidence in one physician, may be actually harmed or prevented from being surgically treated, because his own surgeon under the rules of the hospital cannot operate. Physicians off duty are usually permitted access to the private and semiprivate rooms of the hospital. Good judgment, a sense of fair play and good sportsmanship will prevent the adoption of any rule that will work a hardship to anyone.

How Shall the Hospital Handle Private Minor Surgical Cases?

This question has been asked THE MODERN HOSPITAL by an institutional superintendent who is much disturbed by the problems involved in treating what may be termed minor surgical or medical surgical cases, whose condition does not require that they be admitted as in-patients. Many hospital executives have encountered difficulties in the adoption of a proper system of charges for such hospital service, as well as in the adjustment of this work, which is usually of a sporadic nature, to the daily institutional routine.

Whether every member of the hospital staff should be permitted to send patients requiring treatment of this type from his office to the hospital, and there perform this work himself, is a subject upon which all do not agree. It is true that many hospitals, while themselves departmentalized, have on their staffs physicians who, in addition to their hospital specialty, also practice general medicine in the community. It, therefore, becomes necessary to differentiate between privileges granted such physicians within the hospital, by virtue of their staff position, and those which touch the practice of medicine as it is carried on in their private offices.

Should an internist on the hospital staff be permitted to perform minor surgery in a dressing room because the patient does not remain in the hospital? May a pediatrician incise or excise a carbuncle in the surgical dressing room under gas anesthesia when he would not be allowed to perform any type of operation on an in-patient?

It would appear that the board of trustees should rule that only the type of work a physician would normally perform on patients in his own hospital service may be carried out within any part of the hospital even though such patients are not admitted for treatment. The hos-

pital is equally as responsible, in the last analysis, for the type of work done on these patients, as it is answerable for the skill and efficiency of physicians who are permitted surgically to treat patients who have been admitted to its wards and rooms. A considerable twilight zone separates minor surgery from the so-called medical surgical procedures. The administrator must be the sole judge not only as to the classification of these conditions, but also as to the ability of the physician in question to carry out the grade of work that he asks permission to perform.

In the case of a patient who is suffering with a carbuncle, it would seem that the administrator should require that this patient be admitted to the hospital and that the necessary surgical operation be performed by a member of the hospital's surgical staff.

Usually a flat charge of from \$5 to \$10 is made for this type of case. Arrangements for the use of the hospital facilities for carrying out such procedures should be made through the admission office, and any question as to the validity of such requests should be referred to the administrator for his decision. A minor operating or surgical dressing room should be used for this purpose and patients coming directly from the street should not be allowed entrance into the regular hospital operating suite.

How Shall the X-Ray Director Be Paid?

It would be a fine thing if hospitals could decide upon a general policy covering such important matters as the best method of recompensing the heads of specialty departments.

It would appear, however, almost impossible for a common practice to be followed everywhere because of the variance in the type of the hospital's clientele as well as in the qualifications and temperaments of the directors of institutional specialty departments. Insofar as the x-ray department is concerned, it would appear that there are three general practices followed. The x-ray director may be given a salary, with no fees allowed. He may be given an honorarium of such proportions as to recompense him inadequately for his work, and in addition he may be allowed a stated percentage of the net receipts of his department. He may be given no salary at all but may be permitted a definite proportion, or in certain isolated instances all of the gross receipts.

When a director is on a full-time basis, with salary, he is able to prognosticate his income, and the hospital as well is able to budget its outlay. Yet it can be said that such an arrangement does not offer the same stimulus to the director to perform a greater amount of work in this department, as does the percentage plan. The type of hospital and the personality of the x-ray director have much influence on the satisfactory working of this plan. As has been stated, a minimum salary plus a percentage of the net receipts is often the basis upon which the director of the x-ray department works. It is argued by many that the net and not the gross departmental receipts should be employed in computing the director's salary. Necessary expensive replacements of apparatus and equipment on account of breakdowns, that are oftentimes unpreventable, would be financially devastating to the individual physician, unless some scheme of adjustments is provided.

Stimulation of the x-ray director towards increasing the incomes of both himself and the hospital is to be found in this plan. Where the director receives from 40 to 60 per cent of the gross receipts, his opportunity for

securing a considerable emolument for his services is greatest. He sustains none of the expense of conducting the department but secures a considerable percentage of its receipts. This is perhaps the most favorable plan for the x-ray director but is perhaps the least so for the hospital.

In a recent study of a hospital department, it was found that under this plan the director received two and one-half times as much money from the conduct of this department as did the hospital. Either the flat salary plan or some adaptation of the second scheme mentioned would seem the wisest and fairest for all concerned. Where a percentage of the net receipts is allowed, economy in supplies and a careful supervision of the upkeep of apparatus are practiced.

Is a General Admitting Department Necessary?

In most hospitals, the receiving ward is a feature of long standing and of recognized value. In others, after a cursory examination by an admitting physician of more or less extensive experience, the patient is permitted to enter the ward. This does not appear to be good practice. Not only is a rather thorough physical examination necessary in determining the department of the hospital to which the incoming patient shall be sent, but it is also of great practical service in preventing the exposure to contagion of the patients already in the institution, as well as the contamination of ward clothes rooms by the wearing apparel of verminous patients. Sometimes the presence of suicidal or homicidal tendencies is discovered in the receiving ward, and the proper precautions initiated there. Very often, malingering is detected in the course of this examination and an unnecessary admission is thus avoided.

The receiving ward, therefore, acts as a check to protect in-patient departments against many evils that otherwise could not be avoided. Furthermore, there are developed in the personnel definite skill and team work that are not in evidence when each department is permitted to perform this function for itself.

To What Extent May Staff Physicians Order New and Nonofficial Remedies?

The purchase of drugs entails the outlay of a considerable proportion of the hospital's total expenditure. If only standard drugs and preparations, recognized by the United States Pharmacopeia are purchased, the expense is of large proportions. But when proprietary or semi-proprietary preparations are permitted to be purchased, the financial burden becomes proportionately greater. Many efforts have been made by hospital executives to control the type and extent of drugs purchased. In some instances combinations of drugs, representing favored prescriptions of staff members, are kept in stock and to these are assigned a number or numeral by which they may be designated on the patient's chart.

Interns and staff members are rigorously restricted with regard to ordering these preparations. In such institutions, only the most urgent biologic drugs are permitted. Usually, money may be saved, but objections arise to such a system when it is rigorously enforced. Such a standardization to be wholly successful presupposes the possibility of just as accurately standardizing the condition the drugs are prescribed to relieve. This of course is impossible. Yet the administrator who endeavors to restrict the purchase of new and nonofficial remedies that possess a proprietary taint often meets

the objection that staff members cannot cure patients unless they are given implements with which to work. Nevertheless, he must not cease his efforts because objections arise. There should certainly be some visé of prescriptions which call for expensive drugs coming from the hospital wards. The druggist should not be given full power to purchase proprietary preparations that are not recognized by the council on pharmacy of the American Medical Association. This practice should be frowned upon and the prescription of standard pharmacopeial drugs encouraged. Nonofficial but useful remedies, approved by the above mentioned council on pharmacy, should be permitted. Even in the private rooms where patients are willing to pay for the drugs used, the employment of proprietary drugs should be discouraged.

If the exemplification of the highest principles of medical ethics is not to be found in the hospital, it will be difficult indeed to implant these practices elsewhere. When inordinately expensive drugs are ordered, an interview between the physician who originated the request and the person upon whose responsibility they are to be bought is often fruitful in solving this difficulty.

Should a Hospital of Forty Beds Conduct a School for Nurses?

This question was asked by a member of the board of trustees of a hospital in the Middle West. This institution is losing \$1,000 a month. It averages about forty patients a day, although it has a capacity for sixty. A state inspecting committee has recently required that it affiliate with a children's and a psychiatric hospital. The board does not see how this can be done and considers the wisdom of discontinuing its school for nurses and of engaging graduate nurses.

THE MODERN HOSPITAL can speak only generally in this matter. Adequate experience for nurses is necessary. There can be no evasion on this subject. It is debatable whether a hospital of this bed capacity can offer adequate teaching and clinical experience to meet the requirements of modern nursing education. The training school must not be maintained because it lessens the hospital's annual deficit. On the other hand, while the withdrawal of an educational feature from a hospital always tends to stagnation, it would seem, were such an alteration of policy adopted, that the board should not expect to save much money by changing to graduate nursing.

It has been the experience of many institutions who endeavored to economize in this way that no saving was actually realized thereby. The problem presented to this board should be squarely faced. If inadequate experience is being given pupil nurses, and no remedy is at hand, then the only alternative would be to disband the school. If the care of patients by graduates in nursing requires more money than the hospital can spend, its board should bravely face a mounting deficit or else consider whether the community any longer requires the services of the hospital. To continue a school for nurses purely as a financial venture is an incorrect policy to pursue.

Should Senior Surgical Interns Dress Pus Cases?

Not the least important of the duties of the intern is the maintenance of personal surgical cleanliness, insofar as the dressing of pus cases is concerned. In hospitals in which a junior and senior intern system is operative the former is usually required to dress pus cases, while the latter cares for the dressing of noninfected patients. The handling of infected materials or the contact with

infectious or contagious patients upon the part of the senior surgical intern should certainly be discouraged. In institutions where but one intern performs the duties usually assigned to both senior and junior, a complication arises that is difficult to solve.

Surgeons are often loath to have interns assist in clean surgical operations immediately after having dressed pus cases. In order to avoid the possible danger of infection, an intern may be prohibited from dressing his infected cases on any day prior to operating. These cases are therefore forced to remain undressed until late in the afternoon or early in the evening and perhaps even through a period of at least twenty-four hours.

Theoretically, this practice is sound. Practically, in these days of asepsis, it would seem perfectly safe for interns to take part in operations even though they had but recently been dressing infected patients. Modern aseptic technique, if faithfully exemplified, convinces us that no danger to the patient would be incurred by this practice.

The practice followed in some institutions of having a dresser who is not always a graduate physician and who is responsible for dressing all patients in the surgical department, is not always to be commended. The mere elapsing of a few hours after midnight in the question of not dressing a pus case on the same day with operations does not certainly safeguard or endanger a patient from possible infection. Strict supervision, careful instruction and above all the demonstration by the surgeon of the need for care by practice rather than by precept, should be a sufficient safeguard for patients in this matter.

How May Undertakers be Prevented From Opposing Post Mortem Examinations?

A justly irate staff physician meets a hospital superintendent in the hallway of his institution and informs him that, after his having secured permission for a post mortem examination on one of his deceased patients, an undertaker interfered and caused a withdrawal of the permission. The staff member asks for action on the part of the superintendent in order to prevent a recurrence of this matter. In this particular case the superintendent already knew of the pernicious activities of this specific undertaker along these lines.

It might be wise for the superintendent to explain to the undertaker that constant interference of this sort will not be countenanced in the future, and that the undertaker should appreciate the cooperation of the hospital in the prompt delivery of bodies and the execution of death certificates. If a local association of embalmers exists, the superintendent might even carry his complaints to its officials. A demonstration of friendliness on the part of the hospital, which might take the form of permitting the meetings of this association to be held annually at the institution, of furnishing embalming instruments and fluid, or of showing in other practical ways that the hospital appreciated fair play, has been successfully tried.

An alteration in the methods of performing post mortem examinations to increase the ease of embalming is a practical procedure. When all these steps have been taken to bring about an understanding between the undertaker and the institution's staff on the question of post mortems, but without success, then it would appear that the institution should lay the matter plainly before the undertaker involved, demand fair play and notify him of its opposition to the practice of his business within the hospital.

How Should the Hospital Keep the Record of Alcoholics Used in Treatment of Patients?

Although federal enactments require the hospital to keep an accurate record of all alcoholics used in the treatment of its patients, there is still need for much improvement along this line. It is necessary for the office of the prohibition director to have in its possession, an individual prescription containing the patient's name and covering the amount of whisky prescribed over any period of time.

When a visiting physician or his intern orders whisky, and the prescription has been written upon the patient's chart and is duly signed, it is then the duty of the ward head nurse to secure this drug as she would other therapeutic agents. The amount of her requisition will be determined by a computation of the total number of ounces needed to meet the several orders of the doctor. To this requisition form are pinned the individual prescriptions covering the needs of each patient for whom whisky has been ordered. These prescriptions are filed by the druggist and at the end of the month, are forwarded to the prohibition director's office. It is a good policy for the head nurse of the department to retain a duplicate of each day's whisky requisition, the original having been forwarded to the druggist. With this information at hand, it becomes possible to account upon demand for the amount of whisky used over any stated period of time.

It is less easy to keep account accurately of the alcohol used in the hospital because this drug is employed to preserve specimens in the laboratory and as an antiseptic in the operating and dressing rooms.

The requisition withdrawing alcohol from the drugstore should be preserved in duplicate by the ward supervisor, and the hospital superintendent should receive monthly a statement of the amount of alcohol used as compared with previous months. It is the hospital's duty to preserve accurate records not only of the total amount of alcohol used, but also of the dispensation of each ounce of this drug employed in the treatment of patients. It is unfair both to the hospital personnel and to the federal government to fail to guard against any diverting of this drug to other than therapeutic uses.

Should the Social Worker Collect Fees in the Out-Patient Department?

The term "social worker" is often misapplied. To some, any person who is neither a doctor nor a nurse and who does not represent a recognized hospital specialty is termed a social worker. A clerk assigned to the admission office or to the reception desk in the hospital lobby may be serving society but she is not performing medical social work.

It cannot be gainsaid that a socially minded person is much better able to interpret the ability of patients and their relatives to pay for hospital care than one who has not had the advantage of such training and experience. On the other hand, it would seem best to apply the term "medical social worker" to that person whose duties are largely concerned with the study and treatment of patients.

In a dispensary of size, there must be some individual who is responsible for the collection of fees, but the duties, rank and title of this person should not be confused with those of others medically socially trained, who are endeavoring to aid the physician in learning why the patient is ill and who perform such follow-up work as he

directs. The person to whom financial duties are assigned, may and perhaps should be attached to the business office of the hospital. The social worker should be more closely allied with the medical personnel of the institution. The former may be designated as clinic clerk, financial investigator, or by any other title that seems descriptive of her duties. While ethical medical social workers will not object to performing work not always considered germane to their duties, yet it is confusing not to try to make some differentiation in title to indicate the type of work performed. In smaller dispensaries, it may be that the medical social worker will be required to do financial investigations. This situation, however, should be remedied as soon as possible, that she may have ample opportunity to perform what is perhaps a more important function from the standpoint of the public generally, that of forwarding the study of treatment and prevention of disease.

Who Shall Be Custodian of Surgical and Other Scientific Supplies?

When the administrator of a hospital is not medically trained, he is sometimes much at a loss to pass upon the necessity for the purchase of scientific supplies as well as upon their cost when they are delivered. He feels that the quality and type of surgical instruments are matters he should delegate to others more experienced in their use. The purchase of catgut, ether and gas and the selection of lighted apparatus for diagnosis and treatment, he prefers to turn over to either the chief resident physician, the superintendent of nurses or the operating room supervisor. The replenishment of stock is often left to these persons, and as a result the storage of surgical supplies is frequently placed in the hands of the person delegated to purchase them.

When there are several storehouses about the hospital, there is often a lack of information as to whether articles are on hand that are needed, and as to when the standard stock should be replenished. As a result, a series of emergency demands constantly come to the administrator from the operating rooms or wards. It would seem that surgical and scientific equipment and material should be kept in the same room in which other hospital supplies are stored. The storekeeper and his assistant should be sufficiently trained, so as to be able to recognize at least the major factors necessary to the purchase and issuance of these goods. The operating room from time to time may requisition upon the main stock room through the superintendent for a supply of catgut, gloves and instruments. No department should be allowed, however, to retain more of the standard materials or supplies than are necessary to conduct its work from week to week.

The principle of centralizing all purchases as well as all storage and issuance of surgical supplies is a good one. Any intelligent nonmedical person can be easily trained to recognize the virtues and defects of surgical instruments and supplies. Requisitions covering materials as they are needed not only enable the administrator to check constantly all expenditures of the surgical departments, but they also encourage an economy on the part of the operating room supervisor, because it is necessary for her repeatedly to request additions to her stock. There is much wastage of catgut and other similar supplies, and unless the administrator has control of the standard stock and is able to compare issuance therefrom from month to month, he will be at a great disadvantage in controlling the expenditures of his institution.

NEWS OF THE MONTH

Crowded Attendance and Enthusiasm Feature Pennsylvania Meeting

THE most successful meeting ever held by the Hospital Association of Pennsylvania was concluded at the Bellevue-Stratford Hotel, March 14, after a three-day session. The attendance this year again topped all previous registrations and the exhibits were of more interest and there were more of them than ever before.

The first session was called to order by Dr. E. E. Shifferstine, president of the association, and invocation was asked by the Rev. Floyd W. Tomkins, rector, Church of the Holy Trinity, Philadelphia. This was followed by an address of welcome delivered by Philip H. Gadsden, president, Philadelphia Chamber of Commerce. Mr. Gadsden spoke of the survey that is now being made of the hospitals in Philadelphia and expressed the hope that better hospitalization would result from the work that was being done. A response to his greeting was given by Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia.

New Jersey Delegates Present

One of the features of the meeting this year was the attendance of superintendents from New Jersey. A special invitation had been given to the New Jersey Hospital Association and it was heartily responded to, there being about twenty-five members of that association at the Pennsylvania meeting. It was therefore fitting that the first speaker at the Pennsylvania meeting should be Dr. Joseph R. Morrow, president of the New Jersey Hospital Association and superintendent, Bergen County Hospital, Ridgewood, N. J. Doctor Morrow spoke on "The Role of the General Hospital in a Disease Prevention Program," and emphasized a greater need for preventive medicine in every community. He lauded the work of the American College of Surgeons in the prevention of disease and outlined some of the things that every hospital can do to keep its community well.

The meeting closed with reports from various committees.

On Wednesday morning William M. Breiting, superintendent, Reading Hospital, Reading, Pa., presided in place of Sister M. Bernard, who was unable to be present. Dr. Bert W. Caldwell, executive secretary, American Hospital Association, Chicago, was called upon for remarks and he presented the greetings of the American Hospital Association to the Hospital Association of Pennsylvania. Bromley Wharton of the state department was introduced, and responded with a word of greeting from that department.

The first speaker of the morning was Richard J. Beamish, well known special newspaper man connected with the *Philadelphia Inquirer*, who spoke on "Hospital Pub-

licity." Mr. Beamish gave several rules that could be followed by hospital superintendents in their dealings with newspapers and his remarks were much appreciated by those present. Mr. Beamish's long experience with newspapers of the East qualified him to speak authoritatively on this subject and his statements carried considerable weight with those present. On request from the chairman John A. McNamara, executive editor, *THE MODERN HOSPITAL*, discussed Mr. Beamish's paper. His discussion was followed by a discussion by Dr. B. S. Polak, superintendent, Hudson County Tuberculosis Hospital and Sanatorium, Secaucus, N. J., and by Matthew O. Foley, editor, *Hospital Management*.

Dr. Emil Frankel, director of research, New Jersey State Department of Institutions and Agencies, then told of the cooperation between his department and the hospitals of the state in the gathering and presenting of statistics pertaining to health and hospitalization. This important work, which has gained the attention of the whole country, proved to be a most interesting subject.

The concluding speaker on the program was Dr. E. E. Shifferstine, who delivered the president's annual address. Doctor Shifferstine first outlined the duties and qualifications of a hospital superintendent and then urged the association to consider the elimination of the poorer type of superintendent and the fostering of the better type of hospital administrator. He advocated some sort of an examining board that would pass upon the qualifications of superintendents of hospitals but would have no voice in the management of the hospitals. Doctor Shifferstine pleaded for better work in all of the hospitals and condemned the unethical institutions that permit any type of physician to practice, purely for mercenary reasons.

The entire afternoon of the second day was given over to a symposium on nursing, with S. Lillian Clayton, R.N., director of nursing, Philadelphia General Hospital, Philadelphia, presiding. Mary M. Roberts, editor, the *American Journal of Nursing*, New York, presented the subject, which was a discussion of the recommendations of the Committee on the Grading of Nursing Schools. Many people entered into the detailed study of the subject and at the conclusion Miss Roberts gave a summary of the points that had been presented.

Perhaps the most important report received at the meeting was given by C. S. Pitcher, chairman of the legislative committee. Mr. Pitcher, who is superintendent of the Presbyterian Hospital, Philadelphia, stated that the committee went on record against the pending bill that would allow chiropractors to practice in hospitals. He stated that the bill asking that hospitals take care of veterans of the World War was unnecessary and said

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that such a bill, if it became law, would make it an easy matter for a malingerer to go from one hospital to another, thereby causing the state much expense. Bills amending the workmen's compensation act were endorsed by the committee. Support was asked for the bill that would make it possible for the hospitals to collect their bills from automobile accident cases at the same time the insurance company paid the patient for injuries.

One of the finest addresses ever heard at a hospital meeting was delivered at the annual banquet when William H. Fineshriber, D.D., LL.D., Rabbi, Temple Kenesseth Israel, Philadelphia, spoke on the art of healing, the work of hospitals and the great humanitarian cause so closely allied to religion. Doctor Shifferstine acted as toastmaster and the prayer was given by Rev Leo G. Fink, pastor, Church of the Sacred Heart, Allentown.

One of the features of the meeting was the broadcasting of Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, who spoke over station WFI between 6:30 and 6:45 p.m., on Wednesday.

The Thursday morning session was given over to three papers, "Principles of Out-Patient Administration," by Dr. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, Boston; "Economies in Food Administration," by Katherine A. Pritchett, State Department of Welfare, Harrisburg, and "The Hospital Laundry," by S. Frank Roach, superintendent of laundry, Jersey City Hospital, Jersey City, N. J.

The following officers were elected for the coming year: president, Elizabeth H. Shaw, St. Margaret's Hospital, Pittsburgh; president-elect, William M. Breitingner, Reading Hospital, Reading; first vice-president, L. R. Robbins, Hahnemann Hospital, Scranton; second vice-president, Sister M. Irenaeus, Providence Hospital, Beaver Falls; treasurer, Elmer E. Matthews, Wilkes Barre General Hospital, Wilkes Barre; executive secretary, Howard E. Bishop, Robert Packer Hospital, Sayre; directors, Anna E. Laughlin, Waynesboro Hospital, Waynesboro; Dr. George W. Reese, Shamokin State Hospital, Shamokin; Viola V. Woodward, Blair Memorial Hospital, Huntingdon; Dr. Henry K. Mohler, Jefferson Hospital, Philadelphia; Dr. E. E. Shifferstine, Coaldale State Hospital, Coaldale, and P. W. Behrens, Williamsport Hospital, Williamsport.

The Thursday afternoon program was given over to two round tables on practical problems, one conducted by Melvin L. Sutley, superintendent, Delaware County Hospital, Upper Darby, and the other by Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia.

A delightful trip through the new Hahnemann Hospital was enjoyed by the delegates on Thursday afternoon. A full description of this hospital appeared in the March issue of THE MODERN HOSPITAL.

New Officers Elected for Pennsylvania Catholic Hospital Association

At a business meeting of the Pennsylvania Catholic Hospital Association held at the Bellevue-Stratford Hotel, Philadelphia, March 13, the following officers were elected: president, Sister M. Irenaeus, Providence Hos-

pital, Beaver Falls; first vice-president, Sister M. Carmelita, Du Bois Hospital, Du Bois; second vice-president, Sister M. Regina, Mercy Hospital, Wilkes Barre; third vice-president, Sister M. Mildred, St. Joseph's Infant Asylum and Maternity Hospital, Scranton; secretary, Sister M. Mechtilde, Mercy Hospital, Pittsburgh; directors, Sister M. Avellino, Mercy Hospital, Scranton; Sister M. Thomasine, St. Francis Hospital, Pittsburgh; Sister M. Aloysia, Mercy Hospital, Johnstown; Sister M. Rose, Mercy Hospital, Pittsburgh, and Sister M. Illuminata, St. Agnes Hospital, Philadelphia. The next meeting of the association will be held in Pittsburgh at the same time as the meeting of the Hospital Association of Pennsylvania.

Delegates From Abroad to Attend Protestant Hospital Meeting

Officers of the American Protestant Hospital Association announce an interesting program for their next convention to be held in the Hotel Traymore, Atlantic City, June 14 to 17. The convention dovetails with the International Congress of Hospitals held in the same city, June 13 to 15, and will be followed by the American Hospital Association convention which meets in the Auditorium, Atlantic City, June 17.

Among the attractions of the Protestant convention will be an address by Godfrey H. Hamilton, secretary, National Hospital, Queen Square, London. Mr. Hamilton is one of the ablest hospital administrators of Europe and has studied deeply the question of health services. He will speak Friday night, June 14, on "The Health Services of Great Britain."

Other British delegates invited to the Protestant Hospital Association convention are Captain W. Cockburn, D.S.O., secretary, St. Cross Hospital, Rugby; Rouse Mitchell, secretary, Royal Infirmary, Chester; W. H. Harper, house governor, Royal Hospital, Wolverhampton. Selected delegates from Continental associations are being invited, and in addition representatives of the European Deaconess hospital workers have been invited.

Four round tables having special subjects for consideration have been planned. "Some Requisites for the Proper Conduct of a Hospital" will have sub-subjects such as "The Superintendent," "The Nurse" and "The Doctor," followed by round table discussions. A paper on "Hospital Nursing" will be given by a well known hospital superintendent, followed by a round table continuing the subject. Round table topics will include "The Model Patient," "Training for Bedside Nursing" and "Nurse Specializing."

"The Planning of Hospital Equipment and Furnishings" will be a paper introducing another round table discussion. Several assistants will speak on "Economic Engineering in Appointments," "Providing for Special Departments" and "Arrangements."

"Winning the Public" will be as attractive as hospital leaders can make the subjects of "The Practice of Economy," "Publicity," "Service" and "Administration."

Perhaps one of the most timely subjects will be considered by another group, "What Is the Remedy for the Abnormal Charity Burden Forced Upon Hospitals in Ad-

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mitting and Caring for Automobile Accident Patients?" It is thought that principles governing the admittance and care of such patients should be established. A question to be considered will be: Should automobile owners be compelled to carry accident insurance? "Proposed Standards for Discounts, Vacations and Sick-leaves," will be presented by a committee that made a study of this subject during the year.

From all correspondence it is expected that a large delegation will attend this convention.

Tariff Increases on Surgical Tools —Their Significance to the Sick

Proposed tariff increases on surgical instruments now before the ways and means committee of the House of Representatives would raise the ad valorem duty on such instruments 75 per cent in addition to specific duties, as against the present ad valorem duty of 45 per cent and no specific duty.

"The very large number who would bear the burden of increased duties," a letter from importers of surgical instruments to Isaac Bachrach, chairman of the subcommittee to frame the new proposed tariff, points out, "would be 150,000 physicians, 50,000 dentists, 10,000 hospitals and the enormous part of the population they cater to and to whose needs they administer, and also the medical students throughout the country. The higher prices of instruments would increase the expenses of surgeons, physicians, hospitals and students or even make the purchase of many instruments impossible by excessive cost. This would necessitate larger fees and charges, an additional burden on the sick and injured when they are least able to bear it. The lives of patients may even be endangered because excessive cost would prevent the availability of needed instruments. Surgeons, physicians and hospitals would not purchase certain instruments used only occasionally if their cost were too great.

"The world's source of surgical instruments at present is Germany. A careful estimate of the workers engaged in manufacturing surgical instruments, syringes, needles and accessories in this line totals not over 5,000 and they supply the entire world. If the duties are placed so high as practically to exclude German instruments scarcely more than 1,000 men could be put to work here to supply the deficiency, and a large proportion of these would require years of training. Germany for a hundred years has been the world's source by reason of the experience and skill of workers trained in the industry from generation to generation.

"Supplying the entire world as they do, it pays them to have the dies and equipment to make up the small quantities of individual instruments that each country may use, the aggregate of all countries' wants permitting expenditure for dies and other equipment that would otherwise be unprofitable. This country has no adequate facilities now—factories, equipment or trained workers—to turn out even a small part of the requirements of the profession and it would take years before there could be built up in this country facilities and personnel to produce any important part of the needs. They would then be

produced at an enormously increased cost, profitable to a few manufacturers, benefiting a small number of workers.

"The seriousness and widespread effect of tariff increases on surgical instruments merit the most thorough and careful investigation. Among the organizations opposed to the increases are the American Hospital Association, the Catholic Hospital Association, the American Medical Association and the American College of Surgeons."

The following table sets forth the proposed increase of a 75 per cent ad valorem duty plus the specific duty:

Foreign value per dozen	Specific duty per dozen
up to 25c	12c
25c to 50c	24c
50c to \$1	60c
\$1 to \$2	\$1.50
\$2 to \$4	3.00
\$4 to \$12	4.80
\$12 to \$24	6.00
\$24 and up	7.20

This is instead of the present ad valorem duty of 45 per cent and no specific duty.

Instruments costing abroad per dozen	Plus 75% Specific	Would pay duty per dozen Total Duty	% Duty	Compares with present duty 45%	Increase
\$0.20	\$0.15	\$0.12	\$0.27	135%	\$0.09 200%
.30	.22½	.24	.46½	155%	.13½ 244%
.60	.45	.60	1.05	175%	.27 274%
1.20	.90	1.50	2.40	200%	.54 344%
2.40	1.80	3.00	4.80	200%	1.08 344%
4.50	3.37½	4.80	8.17½	181%	2.03 302%
8.00	6.00	4.80	10.80	135%	3.60 200%
12.00	9.00	6.00	15.00	125%	5.40 178%
16.00	12.00	6.00	18.00	112%	7.20 150%
24.00	18.00	7.20	25.20	105%	10.80 133%

Clinical Pathologists Offer Prize for Research

The American Society of Clinical Pathologists has announced an annual award to be given to the best work in clinical pathology by one of its members. The prize will be known as the Ward Burdick Research Award of the American Society of Clinical Pathologists and is intended to perpetuate the memory of the secretary and co-founder of the organization.

The prize, a gold medal, will be bestowed for some outstanding research project in any of the fields of clinical pathology. It will carry the profile likeness of Dr. Ward Burdick and the nature of the award on its face, while on the reverse side will be the seal of the society, the name of the recipient and the date of presentation.

The award is to be made to the successful candidate by the president of the society at the annual convention on the evening of the banquet.

All candidates for the award must present their thesis at least two months prior to the annual meeting to be held in Portland, Ore., July 5, 6 and 8, in order that it may receive the careful judgment of the research committee. Correspondence should be addressed to the American Society of Clinical Pathologists, Metropolitan Building, Denver, Colo.

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Air Transportation of the Wounded Object of Paris Conference

The first international congress to study the question of the transportation of the sick and wounded by air will be held in Paris, May 15 to 20.

The wide interest aroused and the comprehensiveness of the conference are shown by its lists of patrons and officers. The Queen of Belgium and the President of France, the ministers of war and commerce, of labor and hygiene and the *maréchaux* of France are patrons. Senator Justin Godart, foremost in public health movements, members of the university faculty of medicine, the chief of the army medical service and officers of national medical and pharmaceutical associations are listed. The French Red Cross and the Aero Club of France are represented and the presidents of the companies manufacturing airplanes and automobiles, presidents of railroads, shipping companies and national press associations.

The questions to be considered by the congress are:

The air transportation of ill and wounded by the army and navy and the use of *aviation sanitaire* as a means of evacuation of wounded in wartime.

The international immunization and protection of such transports to be a part of treaty pacts.

Physical conditions of transportation and the treatment of gravely ill or wounded in transport.

The value of air ambulance in health service in times of peace.

Equipment of air ambulances.

In connection with the congress there will be an exposition of air ambulances and equipment in the aerodrome at Villeneuve Orly.

Northern California Dietitians Meet

The northern branch of the California Dietetic Association held a dinner meeting at the Woman's City Club in San Francisco, February 15. Forty-three dietitians were present to hear Doctor Estill, formerly Dr. Nina Simmonds, speak on "The Present Status of Vitamins." She gave a short resumé of the latest findings on each of the several vitamins.

The bill for state registration of dietitians, which has been prepared by Dr. Agnes Fay Morgan, was discussed at length.

F. B. Hagerty, president of the northern branch, suggested a list of institutions to be visited by the dietitians which, she said, would broaden their outlook on the work that is being carried on in the institutions around the bay.

Open Tenth Addition to New York Medical Center

Formal opening of the tenth unit of the new Columbia Presbyterian Medical Center, New York City, was marked with the dedication of the Neurological Institute in March. The out-patient clinics had been open for some time, but most of the work was still being done in the old buildings,

states an announcement in the *Journal of the American Medical Association*.

Robert Thorne, president of the institute, in describing the equipment in the new building, says that there is hardly a device or appliance for reconstruction and re-education of the human mind and body that has not been provided. Specially constructed hydrotherapeutic equipment has also been installed. Featuring this type of equipment there is a peculiarly designed tub in which it is possible for the patient to do reconstruction exercises while bathing.

Record Librarians to Meet in Chicago, October 14-18

The Association of Record Librarians of North America will hold its first annual session in Chicago, October 14 to 18.

It is hoped that the choice of a city in the central part of the country will bring together many record librarians who were too far distant to attend the organization meetings held in Boston last October. Further details of the session will appear during the summer.

Montreal to Welcome Nurses From Nineteen Countries in July

Although a considerable amount of publicity has been given to the Congress of the International Council of Nurses to be held in Montreal, Canada, July 8 to 13, the following brief history with an account of arrangements being made for the congress may be of interest to the nurses who are asking for information about the congress and to those who have decided to attend.

The organization of an International Council of Nurses was proposed by Mrs. Bedford Fenwick at a meeting of the Matrons' Council of Great Britain and Ireland held in London in 1899. The first meeting was held in Buffalo in 1901, but no countries affiliated, due no doubt to the fact that nurses were not sufficiently organized in their own countries to enter into international relationship. In 1904, the United States, Germany and Great Britain affiliated, and in 1909, four more countries were received into membership. At the close of the great Congress in Helsingfors in 1925, nineteen countries were affiliated with the International Council of Nurses. The aim of the council is to raise the standard of education and professional ethics, public usefulness and the civic spirit of its members.

Mabel Hersey, president, Canadian National Association of Trained Nurses, is convenor of the local committee of arrangements for the congress. Miss Hersey's address is Royal Victoria Hospital, Montreal.

From 5,000 to 7,000 visitors are expected to attend the congress and nurses are asked to write for room reservation as soon as possible to facilitate the work of the housing committee. All available rooms in hotels and boarding houses have been secured, so room reservation must be made through the local arrangements committee.

Personals

DR. PORTER E. WILLIAMS, for several years superintendent of the General Hospital, Kansas City, Mo., has become health director of Kansas City.

MRS. CORA M. COCHRANE has resigned as superintendent of the Swift County Hospital, Benson, Minn. GLADYS CHRISTOPHERSON is acting superintendent.

DR. T. R. W. WILSON is acting superintendent of the Greenville City Hospital, Greenville, S. C., following the resignation of MARY A. SMITH.

IRVING S. CUTTER, dean, Northwestern University Medical School, Chicago, has been appointed superintendent of the new Passavant Hospital, which is located on the campus of the university.

CHARLES A. WORDELL, formerly superintendent of St. Luke's Hospital, Denver, has been appointed manager of St. Luke's Hospital, Chicago, succeeding LOUIS R. CURTIS, resigned.

FRANK WALTER, formerly business manager of the University of Colorado Hospital, Denver, is superintendent of St. Luke's Hospital, Denver, succeeding CHARLES WORDELL.

ALMA C. CORBITT has been appointed superintendent of the Charleston General Hospital, Charleston, W. Va., succeeding MAY H. FYE, resigned. MISS CORBITT was formerly superintendent of nurses, Columbia Hospital for Women, Washington, D. C.

ANASTASIA MCCONNELL, formerly superintendent of Mercy Hospital, Charleston, S. C., has been appointed superintendent of the Schenectady Reconstruction Hospital, Schenectady, N. Y.

MRS. MARY E. MARSHALL has been appointed superintendent of the Rutherford Hospital, Murfreesboro, Tenn., to succeed CAROL MARTIN, R.N., who has been acting superintendent.

MARY K. NELSON, R.N., has accepted the appointment as superintendent of the Franklin County Memorial Hospital, Farmington, Maine. DR. A. ROSS was formerly superintendent there.

AGNES P. MCGINLEY, R.N., superintendent, Athens General Hospital, Athens, Ga., has been engaged to superintend the New Community Hospital, Wauseon, Ohio, which is now under construction.

DR. ALBERT A. SUPER, assistant superintendent, Allentown State Hospital, Allentown, Pa., has been selected as superintendent of the Pennhurst State School, Pennhurst, Pa., to succeed DR. EARL W. FULLER, resigned.

HELEN MOLIERE, formerly connected with the South Highland Hospital, Birmingham, Ala., has been appointed superintendent of the Walker County Hospital, Jasper, Ala., to succeed MARY L. SMITH, resigned.

DR. S. A. DOUGLAS, who served from 1912 to 1920 as superintendent of the Ohio State Sanatorium, Mount

Vernon, Ohio, has accepted the appointment as superintendent of the Sunnyside Sanatorium, Oaklandon, Ind. DR. HAROLD S. HATCH was last in charge of the Indiana institution.

HELEN E. MORRIS, formerly on the staff of the Women's Hospital of Philadelphia, has accepted the appointment as superintendent of the Chambersburg General Hospital, Trenton, N. J., succeeding VIRGINIA HUFFMAN, who left to take a position in Brooklyn, N. Y.

DR. J. B. ROGERS has resigned his position as superintendent of the Pottsville Hospital, Pottsville, Pa., and will take up private practice. He will remain as chief surgeon in that institution.

CHARLOTTE MOORE has been appointed superintendent of the Jackson Memorial Hospital, Lexington, Va., to succeed MRS. CLYDE MOOREHEAD, resigned.

MARY E. MORRIS was recently appointed superintendent of the Utica General Hospital, Utica, N. Y., to succeed PEARL A. SMITH, resigned.

MARY B. McKEAU has been succeeded as superintendent of the Kane Summit Hospital, Kane, Pa., by MRS. KATHERINE APPEL, formerly superintendent of York Hospital, York, Pa.

LUCILLE HILL has been appointed superintendent of the Sapulpa City Hospital, Sapulpa, Okla., following the resignation of MRS. DOROTHY HENDERSON.

RAY B. HALL is now superintendent of the Lancaster Hospital, Lancaster, Pa.

JULIA OSTER has been named superintendent of the Greater Community Hospital, Creston, Iowa, to succeed MRS. LENA JARED, resigned.

DR. CHARLES D. STEENKEN is the newly appointed superintendent of the Eastern Shore Tuberculosis Sanatorium, Salisbury, Md., succeeding DR. THOMAS R. PRATT, resigned.

IVA B. HARTMAN, who has been associated with Bellevue Hospital, New York City, has been appointed superintendent of the new county tuberculosis sanatorium at Janesville, Wis.

ALICE SORENSON has resigned her position as assistant matron at Riverside Sanatorium, Granite Falls, Minn., to accept the superintendency of Riverview Sanatorium, Little Chute, Wis., where she will succeed DR. C. D. BOYD, resigned.

DR. OWEN TAYLOR has become superintendent of the Taylor Lacey Hospital, Auburn, Wash., following the retirement of DR. M. J. LACEY to private practice.

VIOLA GREEN has been selected to succeed M. E. WORREST as superintendent of the Carlisle Hospital, Carlisle, N. Y.

PHOEBE MARTIN has resigned her position as superintendent of the Davis Hospital, Pine Bluff, Ark.

Personals

OLIVER H. BARTINE, administrator, Hospital for Joint Diseases, New York City, resigned his position on March 1, to devote himself to hospital consultation work. MR. BARTINE is succeeded by DR. J. J. GOLUB, medical director, Beth Moses Hospital, Brooklyn, N. Y.

DR. HARRY TRAVIS SUMMERSGILL has been appointed superintendent of the Muncie Home Hospital, Muncie, Ind., and will also be superintendent of the new Ball Memorial Hospital, now under construction.

JOSEPH J. WEBER, superintendent, Grace Hospital, New Haven, Conn., has tendered his resignation, to be effective May 15. CHARLES H. DABBS, formerly assistant superintendent, has been appointed to manage the institution temporarily.

D. M. MOLE is now superintendent of the new Toronto East General Hospital, Toronto, Ont., which was opened recently.

DR. J. M. O'DELL, formerly assistant superintendent of Mountain View Sanitarium, Lakeview, Wash., has been appointed superintendent following the resignation of DR. JOHN F. STEELE, who, until recently, has held that office.

PEARL A. SMITH, R.N., has tendered her resignation as superintendent of the Utica General Hospital, Utica, N. Y., in order to accept a similar position at Franklin Square Hospital, Baltimore, Md., where she will succeed DR. W. W. WALKER.

MARGARET A. BANNERMAN, formerly assistant superintendent of Choate Memorial Hospital, Woburn, Mass., has been appointed to succeed MRS. ANNA CURTIS as superintendent of the Mary Alley Hospital, Marblehead, Mass.

ALBERTINA SIX has accepted the appointment as assistant superintendent of the Woman's Southern Homeopathic Hospital, Philadelphia, after having served for four years in a similar position at Muncie Home Hospital, Muncie, Ind.

ELLEN M. SELBY has left the Memorial Hospital, Pawtucket, R. I., where she was superintendent, and MADELEINE M. SCHROEDER, assistant superintendent, is directing the institution until a new superintendent is appointed.

THOMAS F. DAWKINS has resigned his position as superintendent of the United Hospital, Port Chester, N. Y., and on April 1 will become managing executive of a private hospital corporation which operates the Park East Hospital and the Park West Hospital, New York City.

JOSEPH PURVIS, recently appointed as superintendent of the Rogers Park Hospital, Chicago, has severed his connections with that institution.

DR. CHARLES C. HEDGES is the new director of the Babies' and Children's Hospital of the Medical Center, New York City. Before his recent appointment DOCTOR HEDGES was assistant director, Johns Hopkins Hospital, in charge of the out-patient department.

MRS. CLYDE MOREHEAD has left the Jackson Memorial Hospital, Lexington, Va., where she was superintendent, to take a position as superintendent of nurses at the Piedmont Sanitarium, Piedmont, Va.

DR. A. F. ANDERSON was appointed general superintendent, Royal Alexandra Hospital, Edmonton, Alberta, February 1. Prior to that time DOCTOR ANDERSON was engaged in the practice of medicine in Edmonton. He was a member of the attending staff of the hospital, and a member of the board of governors for a number of years.

DR. ANTONIO LAGORIO, director, Pasteur Institute, Chicago, completed fifty years of active medical practice on February 25. DOCTOR LAGORIO was graduated from Rush Medical College in 1879.

MRS. MAE CABLE is the new business manager of the San Antonio Community Hospital, Upland, Calif. CAROLINE VERMILYE, R.N., resigned the superintendency of the San Antonio Community Hospital to become superintendent of the new Redlands Community Hospital, Redlands, Calif. MRS. CARMEN LEHMAN is the new superintendent of nurses at the San Antonio Hospital.

DR. CHARLES H. YOUNG, who has been superintendent of Maine General Hospital, Portland, for a number of years, has resigned to accept the superintendency of Mountainside Hospital, Montclair, N. J. Mountainside Hospital has recently completed a new addition which brings its capacity to near 200 beds.

WILLIAM P. SLOVER has resigned as superintendent of the Burlington County Hospital, Mount Holly, N. J. NELLIE HOWARD has been chosen acting superintendent until a permanent successor is named.

DR. W. R. SEYMOUR, superintendent, Alabama Baptist Hospital, Selma, has resigned to do evangelistic work for the Baptist Church. LUCILLE DUBOSE will act as superintendent until a successor to DOCTOR SEYMOUR is named.

DR. ROY A. MORTER has become medical superintendent of the Kalamazoo State Hospital, Kalamazoo, Mich., after serving fourteen years on the staff.

S. BESSIE BARNES is the new superintendent of Morningside Hospital, San Diego. Prior to going to her new work, MISS BARNES was superintendent of nurses, Westlake Hospital, Maywood, Ill. MABEL A. BRINGGOLD, superintendent of nurses, Ottumwa Hospital, Ottumwa, Iowa, succeeds MISS BARNES at Westlake.

DR. C. P. FARNSWORTS succeeds P. L. LARSON as superintendent of the South Madison Sanitarium, Madison, Wis. DOCTOR FARNSWORTS is the builder of the sanitarium.

ANNA SAMUELSON is the new superintendent of the Odebolt Hospital, Odebolt, Iowa.

DR. ROBERT J. ALEXANDER succeeds DR. FREDERICK E. STRAUP as medical director and superintendent of the Salt Lake City General Hospital, Salt Lake City, Utah.

News of the Month

Hospital Charges Are Increased in Paris

Hospital charges have been increased in Paris. Beginning January 1, the following schedule went into effect: For medical service, charges were increased from 31.88 francs to 35.82 francs a day; for obstetrical service or surgical service, from 33.60 francs to 37.66 francs a day.

Hospitalization in nurseries is raised from 12 to 13 francs daily while charges in the hospitals of the Assistance Publique in cases of work accidents are raised from 35.82 francs to 46.56 francs for medical service, and from 37.66 to 48.95 for surgical service.

According to the *Journal of the American Medical Association*, the budget of the Assistance Publique in Paris for 1929 was voted to the amount of 520,287,964 francs. It comprises a grant of 228,000,000 francs by the city of Paris.

The Conseil général du département de la Seine, which includes the majority of the suburbs of Paris, has voted 50,000 francs for the organization of a technical service of hygiene for the provinces whose special duty will be to study the establishment of new sanatoriums and hospitals.

The Conseil has also voted for immediate use 5,261,667 francs for the establishment of 216 beds for tuberculosis patients in the various hospitals in the provinces; 8,086,130 francs for the establishment of 1,180 beds for sick persons; 1,510,000 francs for beds for old people and cripples; 880,000 for the organization of the Château de Beauregard in Villeneuve-St. Georges, as a hospital center for old people, cripples and incurables, and 8,900 francs for the establishment of first aid stations.

North Carolina Hospital Workers to Meet May 14, 15, 16

Approximately 200 superintendents of hospitals, doctors and nurses are expected to attend the meeting of the North Carolina State Hospital Association to be held in High Point, May 14, 15 and 16. Dr. W. L. Jackson, business manager Guilford General Hospital, High Point, is in charge of the arrangements for the program. In addition to members from North Carolina a number of delegates from South Carolina will attend the meeting.

To Increase Facilities at Edward Hines Jr. Hospital

An important building program is to be put under way at the Edward Hines Jr. United States Veterans' Bureau Hospital, Maywood, Ill., where about \$1,100,000 will be expended to increase the facilities of the institution. Twelve buildings are to be constructed which will permit the addition of 800 beds to the 984 now available at the hospital.

The twelve buildings are to be utilized mainly for the housing of the hospital's personnel. The group will com-

prise two nurses' homes to contain a total of 142 rooms, an eight-room residence to be occupied by the commanding officer, three buildings for attendants, two six-flat structures and five duplex houses for officers.

Quarters for the nurses and attendants will be three stories high, of concrete construction and faced with pressed brick. The flat buildings will be two stories high and will contain four-room suites. The residence for the commanding officer will be two and one-half stories high and will contain eight rooms.

Propose \$30,000,000 for Hospitals in Greater New York

A plan to erect hospitals at an approximate cost of \$30,000,000 throughout Greater New York at points not at present adequately served was discussed at a meeting of the board of directors of the Beekman Street Hospital, New York City, by Dr. William Schroeder, Jr., commissioner of hospitals. The establishment of a central ambulance service under police supervision was also proposed.

The new hospitals, which will be located in Flushing, the Bronx, Richmond, Rockaway Beach and the lower business district of Manhattan will be of medium size sufficient to handle the emergency needs of the communities. Construction of the proposed institutions will extend over a period of several years.

Hospital Leaders on Indiana Program, April 11-12

Representatives of Indiana hospitals who attend the Indiana Hospital Association meeting to be held in Indianapolis, April 11 and 12, will not only participate in discussions of immediate interest to their institutions but they will also have the benefit of suggestions given by leaders of the outstanding hospital organizations in the country.

Dr. M. T. MacEachern, associate director, American College of Surgeons, the Rev. Alphonse M. Schwitalla, president, Catholic Hospital Association, Dr. Bert W. Caldwell, executive secretary, American Hospital Association, the Rev. J. H. Bauernfeind, president, Protestant Hospital Association, and Dr. Louis H. Burlingham, president, American Hospital Association, are to take part in the program, and each will have something of interest to say to those attending the sessions. Albert G. Hahn, business manager, Deaconess Hospital, Evansville, and president, Indiana Hospital Association, is in charge of the program. He will also preside at the opening session which begins at ten o'clock Thursday morning, April 11.

Following the invocation at the opening session the address of welcome to the delegates will be made by an official of the Indianapolis Chamber of Commerce. Dr. Charles N. Combs, superintendent, Union Hospital, Terre Haute, Indiana, will give the response. Doctor MacEachern's address has as its subject, "The American

News of the Month

College of Surgeons' Survey of Indiana," a discussion of which is to be given by Dr. M. F. Steele, superintendent, Hope Methodist Episcopal Hospital, Fort Wayne, and Mrs. L. Luella Cox, R.N., superintendent, Methodist Hospital, Gary.

Mrs. Ethel P. Clarke, director, school of nursing, University of Indiana, Indianapolis, will preside at the afternoon session, April 11. "Planks for the Hospital Program, 1929," is the subject on which Doctor Caldwell will speak. An address by Father Schwitalla is to be discussed by C. H. Young, superintendent, Indiana Christian Hospital, Indianapolis. John A. McNamara, executive editor, *THE MODERN HOSPITAL*, Chicago, will conduct a round table discussion on hospital economies. The first day's sessions will close with a banquet and dance for the attending delegates. An exhibit is to be an important part of the program.

The second day's session will begin at 9:30 a.m., with Dr. William A. Doeppers, superintendent, Indianapolis City Hospital, Indianapolis, presiding. An address, "Wings or Weight," will be given by Dr. L. H. Burlingham, which will be followed by a discussion. "A Practical Hospital Problem," is to be presented by Dr. J. H. Bauernfeind, and this will also be discussed. "Why One Hospital Succeeds More Than Another," is the subject of an address to be given by Matthew O. Foley, editor, *Hospital Management*, Chicago. A discussion will follow Mr. Foley's address. A business session will be held after luncheon. A visit to Indianapolis hospitals will complete the day's program. The exhibit will be open at all times throughout the entire session and will be a feature of great interest to delegates.

Clinical Pathologists Organize Registry of Technicians

In accordance with the trend of the times, the practice of medicine is utilizing more and more the services of trained lay help, according to Dr. H. J. Corper, secretary-treasurer, American Society of Clinical Pathologists, Denver, Colo. The advent of the laboratory as an indispensable aid to the diagnosis of disease has created a new specialty in medicine, that of clinical pathology.

To carry on the numerous technical tests required in scientific diagnostic procedures, the laboratory director has found it necessary to train the technical personnel. With the standardization of hospitals and the urgent call for qualified laboratory assistants there has arisen a demand for proper standardization of the preliminary education and technical training of those enrolled in this new profession.

There has also been a desire on the part of those engaged in this useful calling to raise their status, similar to the evolution of the trained nurse of a generation ago. This want is now being taken care of by a national organization consisting of a body of men who are most vitally interested in elevating the intellectual and technical status of laboratory workers. The American Society of Clinical Pathologists has taken upon itself the task of organizing a Registry of Technicians with rules under which those qualified by education, technical in-

struction and moral character will receive a certificate.

The subject is of interest to physicians in every field of endeavor as many of them are desirous of securing the services of technicians to carry on the routine laboratory procedures.

There is no doubt that the elevation of the laboratory technician to the status of a respected and useful calling will be a great help to the medical profession, to the patient and to the scientific practice of medicine.

The headquarters of the Registry of Technicians, American Society of Clinical Pathologists, are located in the Metropolitan Building, Denver, Colo.

Another desirable feature of the registry is the facilities it offers in finding suitable placement for registrants and in aiding physicians to find desirable applicants.

Julia P. Wilkinson to Do Field Work With Nurses' Association

Julia P. Wilkinson, R.N., M.A., joined the staff of the American Nurses' Association, March 15, as field secretary. Her immediate task will be an extensive field work study of nurses' registries. Nurses are looking to registries to become decisive factors in working out solutions for the problems of private duty nurses. Registries are also expected to take an important part in working out a more effective and economical distribution of nursing service in order that the nursing needs of all types of patients may be met in epidemic periods as well as throughout the year.

Miss Wilkinson is a graduate of Massachusetts General Hospital and of Wellesley College, and has completed the course of study in public health nursing at Teachers College, Columbia University. She had five years experience as placing out visitor with the Boston Children's Aid Society before she took up nurses' training. Her nursing experience has been broad, including private duty and public health work in rural sections, in cities and also abroad.

Chicago University to Have Large Children's Medical Center

Building permits have been granted to the University of Chicago for buildings to be used as a children's medical center, which, when completed, will represent an investment of \$7,000,000. This, according to *School and Society*, will compare favorably with the famous children's medical center in Vienna, Austria. It is planned to have the new buildings completed by June, 1930.

Among the new buildings will be the McElwee Memorial and the Hicks Memorial Orthopedic Hospital, which are to be surgical units. These buildings will house the Home for Destitute Crippled Children. The Bobs Roberts Memorial, the Charles Gilman Smith Contagious Disease Hospital, the new Chicago Lying-In Hospital and the Country Home for Convalescent Children are other buildings that will add to the size and completeness of the medical center.

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News of the Month

Santa Barbara Cottage Hospital Gets Gifts of \$1,270,000

Gifts to the Santa Barbara Cottage Hospital, Santa Barbara, Calif., during 1928 totaled more than a million dollars and included contributions to the research endowment fund, to the building fund, to the construction fund for a new addition to the hospital, to the endowment fund for children and to the maintenance endowment fund.

Three gifts of \$200,000 each were contributed as a research endowment fund, and as a building fund. Of these gifts \$500,000 has been invested as an endowment fund, the income from which will be used for medical research work; \$100,000 of the fund was used for building purposes. The research work at present is confined largely to research studies of metabolic diseases and also research into the cause and treatment of cancer. The three contributing \$200,000 each were Major Max Fleischmann, Edward L. Harkness and George Owen Knapp.

At the annual meeting of the Santa Barbara Cottage Hospital Association in January, 1929, a gift of \$500,000 from Major Max Fleischmann for the construction of a new addition to the hospital was announced. This addition will be four stories in height, the ground floor being devoted to classified store rooms and work rooms. The second story is to house a surgical unit of thirty-seven beds together with a receiving unit. The third floor will house a maternity department having twenty-three beds, nursery and isolation rooms. The fourth story will contain the x-ray department and operating rooms. Extensive alterations will be made to the power and laundry plants. New kitchens will be built.

The hospital also received an endowment fund of \$50,000, the income from which is to be used to maintain free beds for children. In addition to this, an endowment fund of \$120,000 was announced at the annual meeting, the income from which will be used to cover a portion of the maintenance cost of the new addition with the view of making the rates in both the maternity and surgical units of this addition as low as possible to permit of their use freely by patients with moderate incomes.

The gifts all told totaled \$1,270,000.

Will Establish Free Consultation System in New Orleans Hospital

Hôtel Dieu Hospital, New Orleans, La., operated by the Sisters of Charity, will in the near future inaugurate a system that will give free consultant service to its patients. It will be the first hospital in the United States to give such service. The hospital, with its visiting staff of 125 physicians and surgeons, will donate this service to any patient unable to pay for it. Any doctor in doubt as to the diagnosis or treatment will automatically call in as many consultants on the staff as are required, such a procedure being necessary, both as a matter of ethics and of an increase of skill by collective knowledge.

This system, according to Dr. James T. Nix, president of the board of directors, will be of special benefit to the middle class of the population who cannot afford to pay

for this service. It will put the best surgical and medical talent within the reach of poor and rich alike.

Under the new plan a complete history of each case will be compiled including examination of patients on their entrance into the hospital and all subsequent consultations. This service, it is estimated, will be worth about \$365,000 annually. The cost of this service, however, will be offset by the benefits it brings to the community and to the scientific investigations of the doctors.

To Issue Year Book of Social Work

Social work is to join the other groups whose progress is recorded in a year book, to be issued by the Russell Sage Foundation under the editorship of Fred S. Hall of its staff, according to the *Bulletin* of the American Association of Hospital Workers. That there is demand for information each year about social work is shown by the space given to it in the three comprehensive annuals now issued—the American Year Book, the New International Year Book and the Americana Annual. Taken together they print articles on thirty-two different national organizations in the field of social work, and additional articles on forty-two topics in that field. The new year book, besides including such organizations and topics, and giving them a more uniformly adequate treatment from the standpoint of social work, will cover also many fields of activity which do not appear in these general annuals at all.

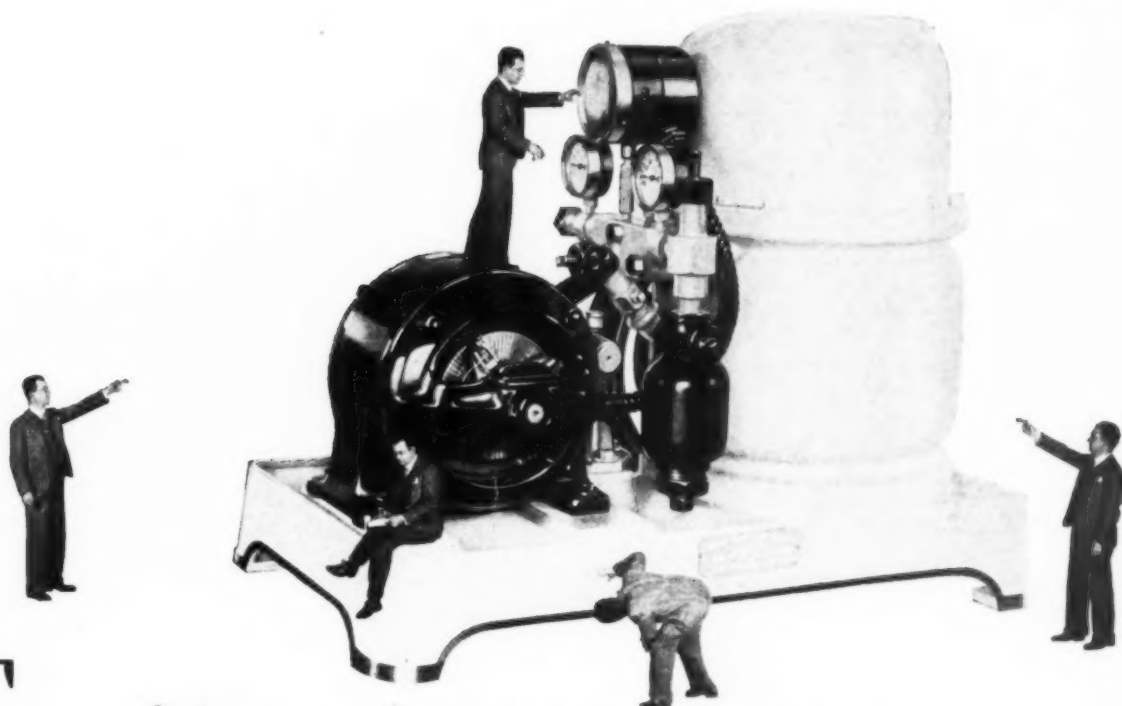
Brooklyn Hospital Plans New Nurses' Home

With \$200,000 in hand and an equal amount being solicited authorities at St. Catherine's Hospital, Brooklyn, N. Y., are planning the construction of a new six-story nurses' home. The new home will accommodate about 125 nurses.

At present the hospital has a staff of ninety-eight nurses who are now housed in four homes scattered around the hospital. The plan is to do away with the scattered housing. In the new building will be classrooms, demonstration rooms, a chemical laboratory, a dietetic laboratory, an auditorium with seating capacity of 300, a library, rooms for the use of visitors and a reception room.

New Cancer Institute to Be Built Shortly

That work is to begin shortly on the new Cancer Institute that is to be built near the San Francisco Hospital is announced in the February issue of *California and Western Medicine*. Funds for the building are provided out of the recent health bond issue. The building, it is estimated, will cost about \$400,000.



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News of the Month

New \$450,000 Wing Now in Operation at Mercy Hospital

With the completion and the subsequent operation of the new \$450,000 wing of Mercy Hospital, Gary, Ind., 1928 may be counted as one of the memorable years in the history of the hospital. The entire hospital building, which includes the new wing, now presents a base line of 390 feet.

The first floor of the new wing houses the administrative offices and one of the most complete x-ray and physiotherapy departments in the state. The basement contains an auditorium and refectories for the Sisters, as well as various utility rooms.

The fifth floor shelters a surgical department that takes rank with the outstanding surgeries of the state. Four major operating rooms and several minor operating rooms, constructed of Alabama marble, green tile and terrazzo, are equipped with the most modern and scientific apparatus. On this floor is also the children's department.

Patients' rooms on the second and third floors are furnished with cheerful and homelike furniture.

The obstetrical department runs the entire length of the fourth floor of the hospital and offers two reception rooms, two labor rooms, utility rooms, a diet kitchen and rooms for the maternity patients. The nursery on this floor was remodeled and large glass windows were installed to permit visitors to view the infants from the hall. New equipment was also provided for the nursery.

Mercy Hospital is run by the Sisters of the order of Ancilla Domini. Sister Alphonsine is the superintendent.

University of Chicago Announces Nursing Courses

The University of Chicago, Chicago, is announcing its nursing courses for the coming summer quarter. According to Anna D. Wolf, associate professor of nursing, University of Chicago, five courses will be offered to qualified, registered, graduate nurses covering public health nursing, supervision in schools of nursing, methods of teaching the principles and practice of nursing and administration in schools of nursing.

\$2,000,000 Gift to Expand New Haven Hospital

Yale University has received a gift of \$2,000,000 from the General Education Board, New York City, for a new medical and pediatrics laboratory and a dispensary and service unit on the grounds of the New Haven Hospital, New Haven, Conn., which is affiliated with the Yale School of Medicine. The announcement of the gift was made by James Rowland Angell, president, Yale University.

Six stories in height, the dispensary and service unit will become the center of the modern group which is

gradually replacing the old buildings. The central unit will occupy the site of the original hospital building erected in 1833. It will contain offices, examining and treatment rooms, research laboratories and teaching facilities for internal medicine and the diseases of children.

Hospital Physicians Plan Trip to Foreign Clinics

Dr. Karl Meyer, medical director, Cook County Hospital, Chicago, Dr. Harry Culder and Dr. Harry Katz of the hospital staff, are planning a visit to clinics in London, Paris, Heidelberg and Vienna starting April 20. They will also make a study of cancer research while they are visiting the medical centers in Europe.

Coming Meetings

Alabama Hospital Association.

President, Dr. French Craddock, Sylacauga.

Secretary, Clara Wells, R.N., Eufaula.

Next meeting, Mobile, April 16.

American Association of Hospital Social Workers

President, Gertrude L. Farmer, Boston City Hospital, Boston, Mass.

Secretary, Helen Beckley, 18 E. Division St., Chicago.

Next meeting, Atlantic City, N. J., June 17-21.

American Hospital Association.

President, Dr. L. H. Burlingham, Barnes Hospital, St. Louis.

Secretary, Dr. B. W. Caldwell, 18 East Division Street, Chicago.

Next meeting, Atlantic City, June 17-21.

American Protestant Hospital Association.

President, Rev. J. H. Bauernfeind, Evangelical Deaconess Hospital, Chicago.

Secretary, Dr. Frank C. English, Hyde Park, Station O, Cincinnati.

Next meeting, Atlantic City, June 14-17.

Catholic Hospital Association.

President, Rev. Alphonse M. Schwitalla, Medical School, St. Louis University, St. Louis.

Secretary, Sister Irene, St. Mary's Infirmary, St. Louis.

Next meeting, Chicago, May 6-10.

Georgia Hospital Association.

President, Dr. Joe R. Clemmons, Macon Hospital, Macon.

Secretary, J. B. Franklin, Baptist Hospital, Atlanta.

Next meeting, Macon, May 7.

Indiana Hospital Association.

President, Albert G. Hahn, Deaconess Hospital, Evansville.

Secretary, Gladys Brandt, Cass County Hospital, Logansport.

Next meeting, Indianapolis, April 11-12.

International Hospital Congress.

Next meeting, Atlantic City, N. J., June 13, 14, 15.

Michigan Hospital Association.

President, Dr. Charles E. Stewart, Battle Creek Sanitarium, Battle Creek.

Secretary, Robert G. Greve, University Hospital, Ann Arbor.

Next meeting, Battle Creek, April 25-26.

Minnesota Hospital Association.

President, Dr. Donald C. Smelzer, Charles T. Miller Hospital, St. Paul.

Secretary, Joseph G. Norby, Fairview Hospital, Minneapolis.

Next meeting, Rochester, May 10-11.

National League of Nursing Education.

President, Elizabeth C. Burgess, Teachers College, Columbia University, New York City.

Secretary, Nina D. Gage, 370 Seventh Ave., New York City.

Next meeting, Atlantic City, N. J., June 17-21.

New Jersey Hospital Association.

President, Dr. Joseph R. Morrow, Bergen County Hospital, Ridgewood.

Executive Secretary, W. Crane Lyon, 201 Lyons Ave. Newark.

Next meeting, October 4-5.

Hospital Association of the State of New York.

President, Dr. John E. Daugherty, Jewish Hospital of Brooklyn, Brooklyn.

Secretary, Dr. Marvin Z. Westervelt, Staten Island Hospital, Staten Island.

Next meeting, Rochester, May 16-17.



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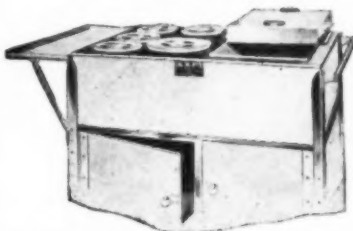
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News of the Month

New Maternity Department Increases Facilities at Georgetown

Formal opening of the new maternity department at Georgetown University, Washington, D. C., with a capacity of approximately seventy-five beds and providing special arrangements for the handling of twilight sleep cases, took place in February.

Another feature of the hospital arrangements is the semiprivacy afforded the patients by a suite of rooms provided with two beds and a suite of sleeping apartments for physicians, to be used in cases of emergency. There are three large delivery rooms, two for white patients and one for colored, in addition to a special arrangement for the care of maternity cases in their early stages.

With the opening of the new maternity department, additional space was released in the old department which will be converted into three operating rooms for the treatment of nose and throat cases. One of the floors which was vacated will be used for a gynecological department. Thus the total number of operating rooms in the institution is increased to nine.

Honolulu Is Ideal Meeting Place for Pan-Pacific Conference

Because Honolulu, Hawaii, is the crossroads of the Pacific, the center of Pacific affairs and the bridge from the Occident to the Orient, it is ideal as a meeting place for the Pan-Pacific Surgical Conference that is to be held there August 14 to 24.

Surgeons from all countries, states and nations bordering on the Pacific are expected to attend. The conference, which is called by the Pan-Pacific Union, means the exchange of surgical ideas and teachings of international scope. If more than 200 delegates attend, the Moana Hotel on the celebrated Waikiki Beach will be turned over in its entirety to be used as conference headquarters.

Subjects to be discussed will be limited to surgery, its specialties and hospital standardization. Each country is to select surgical subjects of particular interest to its workers. No routine clinics are to be held. Any man who has any new technique is to be given the opportunity to demonstrate it. Ordinary technique is to be presented only by moving pictures. Case presentations or dry clinics are to be particularly encouraged, these subjects to be presented between 7:30 and 8:30 o'clock each morning.

The presentation of papers will take place between 9 and 11 a.m., with only the synopsis to be given by the reader, the full papers having been distributed at least two days prior to the meeting to the three men who are to discuss the paper. Round table discussion will be held from 11 to 12:30 o'clock among groups of men who are particularly interested in specific subjects. One afternoon is to be devoted to a special clinic on leprosy to be held at Kalihi Leprosarium and one afternoon is to be devoted to hospital standardization.

According to the entertainment program that has been planned, there will be no official hotel banquets, the open

night, August 14, to be featured by the reception given by Governor Wallace R. Farrington. On Saturday afternoon, August 17, a Hukilau, which is the old Hawaiian custom of drawing in a half-mile long net with hundreds of fish and then feasting on them on the beach, will be held on the other side of the island. A trip around the island will be made on Sunday. The large official feast will be a Luau at Waikiki on August 22, this to be followed by an Hawaiian night. This native feast will represent the glowing color of the monarchical days of Hawaii with its famous dances, songs and stories. The following night, an Oriental night in Hawaii will be presented by Japanese, Korean and Chinese students—a program filled with the pageantry of the Orient.

Nursing Leaders to Attend Catholic Guild Convention in Montreal

Leaders in the nursing profession from the United States, Canada and Europe will participate in the program of the International Catholic Guild of Nurses at the meeting of the guild in Montreal, Canada, July 5, 6 and 7. The interests of Catholic schools of nursing will be discussed at this meeting. Special excursions will be conducted from various sections of the country to Montreal, Canada. A special train will be made up in Chicago to carry the nurses from the West and the Middle West on a tour that will include the most interesting features of the United States and Canada, allowing a week at Montreal to participate first in the program of the International Catholic Guild of Nurses and then in that of the International Council of Nurses.

Invitations have been sent to groups of nurses in Europe to attend the convention of the guild, and the program will be both in English and French with special sessions for the Sisters who attend. The French sessions are necessary for the French-Canadian nurses and for the visitors from Europe who can more readily understand French than English. Round table discussions are to be an outstanding feature of the program.

The headquarters of the International Catholic Guild of Nurses are at the Auditorium Hotel, Chicago.

Christian Science Sanitarium Started in San Francisco

Excavation work is under way for a new \$1,000,000 Christian Science Sanitarium in San Francisco, Calif., which is to be completed in about a year, according to an announcement made by officials of the church.

Details of the construction will include a main building and two wings, built of reinforced concrete. The architecture will be patterned after the chateaus of northern France, and the buildings will occupy a site two blocks square.

A variety of recreation and assembly rooms will be provided, in addition to 120 guest rooms. Opportunity for study, rest and healing will be provided.

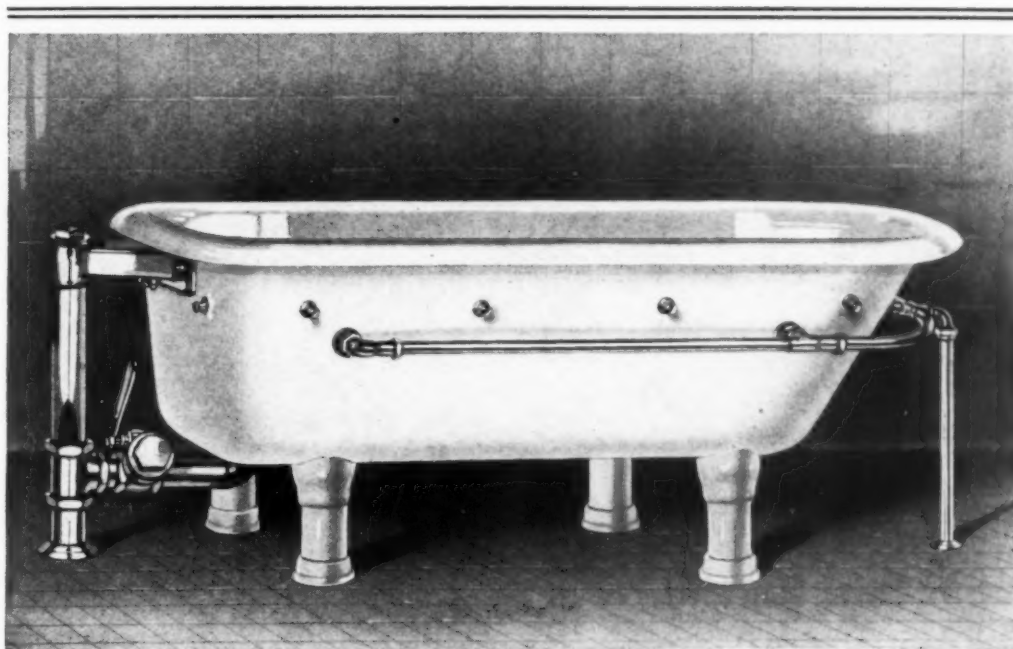
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NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

Why Not Make Graduate Courses in Nursing Actually Educational?

By GRACE G. GREY

Superintendent of Nurses, Jewish Hospital, St. Louis

ADULT education has become a part of the responsibility of schools of higher learning. To-day students who finish college no longer feel that they are through with study forever and can henceforth devote their time and energy to earning a livelihood. To them graduation from college marks but the beginning.

The bachelor's degree is the first step. Following this a large majority of these graduates study towards a master's degree or a doctorate, or they take up a profession such as law or medicine. Teachers are required to return to college every summer for additional work if they would progress in their work. These graduate students are an inspiration to any institution. They come with a full-fledged knowledge of their needs, and they study with an earnestness that is lacking in the majority of younger students.

Schools of nursing in order to keep pace with other educational institutions must also provide postgraduate study and experience for their students, and in a great many of our larger institutions postgraduate courses are offered. There are, however, many glaring weaknesses in these courses. A graduate nurse has already learned the minor procedures and routine of nursing technique, but in the majority of instances this fact is not taken into consideration at all. In a college the student is not required to spend any time in a review of the subjects that he has studied and passed. He does not need to spend long hours in laboratory work that he has already mastered. In fact, he is not allowed to take for credit any subject for which he has already received credit.

Weaknesses of Postgraduate Courses

Yet this is precisely what happens to the graduate nurse who wishes to specialize or take advanced work. She is often treated like a stepchild in a large and unsympathetic family. She is required to spend a major portion of the time in routine work that in many instances could be delegated to an attendant. She receives little if any instruction and must take "pot luck" with students and general duty forces. When she finishes her course of three or four months she has gleaned from her experience practically a month of genuinely worth while work. The other months have been nothing more than waste motion.

In this connection may be cited the example of the director of a large school of nursing who felt the need of additional work in obstetrics. Her own training in this department had taken place ten years before and she did not feel qualified to direct obstetrical work without further study of modern methods. She applied to one of the leading hospitals of the country for permission to take postgraduate work. For the first month her duties consisted mostly of washing soiled linen, mending gloves, putting up supplies and cleaning the utility and labor rooms, with a few hours of observation of deliveries. Yet this same woman was a high salaried individual in charge of a school of 150 student nurses and she was using a needed vacation along with a leave of absence to take postgraduate work. This is merely one instance. When interviewed postgraduates invariably give the same answer: "We do not want to be quitters and so we stay. But it isn't fair. Of course, in the end we really get some good material."

The Student Should Decide for Herself

Does this not seem like a foolish waste of time? Is it not high time to begin to study our methods intelligently and to put our nursing schools on an educational basis? Why not charge for these advanced courses of nursing and then make them distinctively and distinctly educational in nature? Nurses from all over the country are wishing vainly for some such system. It is entirely too expensive to give up several months' salary to learn the same things that were learned as a probationer. What she wants are new methods, new treatments and new systems, and she should be able to acquire these as speedily as possible, just as she is in a postgraduate academic school where the students are allowed to decide for themselves what their needs are and to plan their courses accordingly.

Postgraduate courses should not be arranged haphazardly. The background of the students, the schools from which they come, the curriculum pursued and the aim of the students should all be taken into consideration. If the nurse merely wishes to do additional work to test her speed and efficiency then she should be allowed credit for such work. No hospital has the right to take a graduate's time and energy for its own selfish ends. It is not fair to use a postgraduate student to fill vacancies during vaca-

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tions or to round out an insufficient force. The postgraduate should supplement the service and not complete it. The work of the graduate should be carefully allotted and supervised. There should be a student adviser to confer with the student at stated intervals just as there is in a college.

Postgraduate students in a hospital are often made to feel guilty if they presume to discuss the course with the supervisor or seek to confer with the superintendent of nurses. Yet this is exactly what should be done. The postgraduate nurse should be made to feel that she is free at all times to consult her supervisor; she should, in fact, be required to do so. An instructor should be employed to teach the theory of the course, to give practical demonstrations and to follow up the student in her laboratory work. The work assigned should be of such a nature that the student's previous study is supplemented and her needs satisfied. Theoretical and practical examinations during the course and a final examination at the end of the course would serve as a basis for rating the student's ability.

Providing New Methods and Technique

Nurses from inferior schools who find it necessary to take a postgraduate course in order to secure a position, and students who have been out of nursing for many years or who have been doing only one type of nursing and feel the need of a review find the postgraduate courses as they exist to-day of considerable value. To the woman whose background has been excellent but who wishes to prepare for a special field of nursing work, the infinite amount of routine required is not only irksome but criminally wasteful of her time and energy. For the executive and teacher who cannot get away for any great period of time the only courses open are those given by various universities during the summer months. These courses are inspirational, but they do not meet a practical need.

After a few years the institutional nurse needs to revive her nursing interest and knowledge by learning new methods and technique. If hospitals would arrange to give a six or eight weeks' course in the various specialties, employing a full-time instructor and charging for the course at university rates, many executives and instructors would consider their time well spent in attending. Would it not also be an inspiration to the school to have these alert, intelligent women as students? The experience and knowledge they would bring to the work would give an impetus to renewed thought and action; on the other hand such a course would enable many superintendents and instructors to rekindle their enthusiasm and return to their jobs prepared to give more of value and inspiration to their own students. It would also be a stabilizing element in professional life.

The whole problem of the postgraduate student goes back to the days of apprenticeship service. It is hard to get away from this manner of thinking. Much has been done for student nurses because they have been needed. The postgraduate student is not especially needed. In fact, she is often not wanted. She is one of the hospital personnel only for a short time and, therefore, her value to the institution is curtailed. The hospital has generally valued the postgraduate in the light of service to the institution, and not in the light of the hospital's service to her. Her status as a graduate, therefore, has not been recognized; neither has her prerogative to demand an educational program.

The attitude of the hospital is one of indifference to the postgraduate's opinion of the service she is receiving. If she does not like it she need not stay.

Human Welfare Group at Yale Receives Millions in Gifts

Gifts amounting to \$10,500,000 made within the last few weeks to Yale University will contribute to the development of the school of medicine and allied interests, according to President James Rowland Angell. The outstanding gift was that of a group of foundations to be used for the work of the Human Welfare Group which has gradually been taking shape at Yale.

Formation of the Human Welfare Group has been termed by such an authority as Dr. William H. Welch of Johns Hopkins University the first important step that has been taken in medical education in the present century and a highly important one from the point of view of education generally.

Associated units in the Human Welfare Group are the fundamental science departments, biology and chemistry, and their branches; the school of medicine and the school of nursing; the New Haven Hospital and the New Haven Dispensary and the institute of human relations for research in the social sciences, in psychology and psychiatry. Closely associated with the group is the school of law, which is concerned with the application of social science, just as medicine is concerned with the application of biology.

The various units in the Human Welfare Group will continue their customary activities in teaching, research and treatment of patients. In order to facilitate the work of each and to bring all into constant contact with each other a group of buildings largely centered around the school of medicine and the hospital will be developed. A completely modern set of buildings for the New Haven Hospital and Dispensary and for the school of medicine is already well under way. The school of nursing, now occupying hospital and school buildings, will eventually have its own residential and instructional centers, it is hoped. The institute of human relations is to be housed in a \$2,000,000 building to be erected in the proximity of the hospital.

Saint Teresa College Offers Special Nursing Courses

In connection with the combined course in nursing and liberal arts leading to the degree of bachelor of science in nursing, Carolyn E. Gray, B.S., A.M., Columbia University, member, National League on Nursing Education, and chairman, Department of Nursing Education in Colleges and Universities, is at the present time offering the following courses at the College of St. Teresa, Winona, Minn.: history of nursing, nursing school organization, principles of nursing education and special methods of teaching, survey of the nursing field.

The courses offered by Miss Gray are open only to those students who already hold the certificate of registration and who are registered for the bachelor's degree.

Students taking these courses at the college are from the following hospitals: St. Francis Hospital, Peoria, Ill.; St. Anthony Hospital, Rockford, Ill.; St. Joseph Mercy Hospital, Dubuque, Iowa; St. Joseph Mercy Hospital, Mason City, Iowa; St. Joseph Mercy Hospital, Ann Arbor, Mich.; Leila Y. Post Montgomery Hospital, Battle Creek, Mich.; St. Mary's Hospital, Rochester, Minn.; Mercy Hospital, Portsmouth, Ohio; Providence Hospital, Sandusky, Ohio; Good Samaritan Hospital, Zanesville, Ohio; Holy Family Hospital, Manitowoc, Wis.

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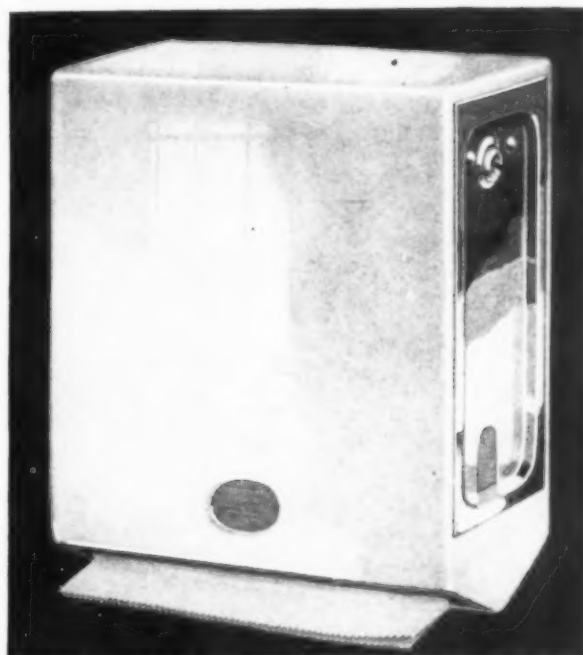
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A Successful Combination of Class and Recreation Rooms

ALTHOUGH it is not a new idea to combine class and recreation rooms for student nurses, it often results in dreary and unattractive recreation rooms. A successful combination can be made, however, if the furnishings are carefully chosen and other incidental matters well thought out. Such a combination has been accomplished by the hospital of the University of Pennsylvania, Philadelphia.

The rooms used were parts of a remodeled building, two ten-bed wards, nearly square, and a sixteen-bed ward, a narrow oblong. The entire space was needed for lecture and classrooms and also for recreation rooms. No other space was available for either purpose. The problem appeared insoluble but brains, ingenuity and good taste proved that it was not.

A moving picture booth was needed. This was provided by building it at one end of the long, narrow ward. It was made as shallow as possible and the approach was from the side farthest from the door. A person entering the room is not even conscious of the existence of the booth, its asbestos walls being painted like the other walls of the rooms, a warm yellow-buff. The silver screen for the pictures was fixed permanently at the opposite end of the room in a space about eight by ten feet.

Installing Blackboards

The next problem was that of blackboards. Portable blackboards, because of their small size, constitute a storage problem when rooms are used for recreation. Wall blackboards were therefore installed. In the narrow ward they were placed on each side of the movie screen, and in the square rooms on the side that afforded a clear space near the center of a wall. Over the blackboards and the picture screen were hung draperies, operated by pull cords, so that they could be covered or exposed at a moment's notice. These draperies were a fairly expensive item, but they were well worth the money, since they add greatly to the beauty of the rooms. The draperies in the long ward are of rose-taupe velvet. Separate curtains were made for each of the blackboards and for the picture screen. These curtains cover the entire end of the room. Those in the other rooms are lined tapestries.

The floors were covered with the original linoleum, a dark tan. This was cleaned, waxed and left in place. A mottled linoleum or a hardwood floor would have been more attractive. Rugs may be bought later, although they have not been needed as yet.

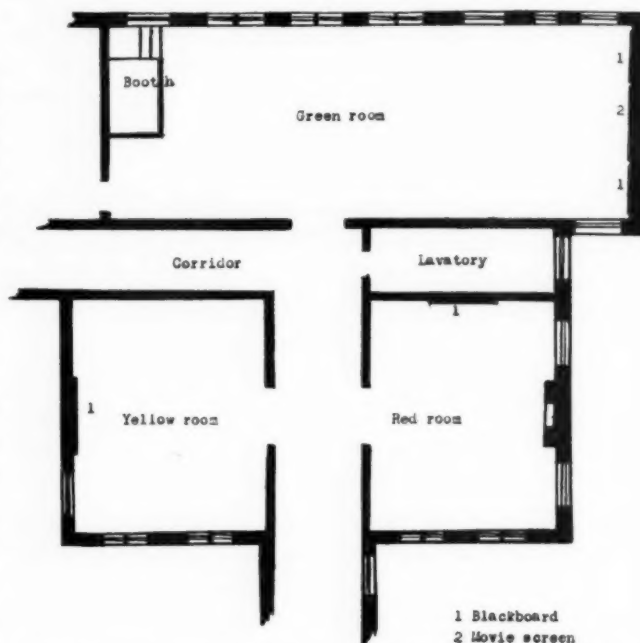
For window shades, dark green, lightproof material was used, fitted tightly to the casings, since it was desired to use the square rooms for lantern work when the long room was occupied with movies. Straight drapery curtains were hung at the windows.

So far, all three rooms had the same color scheme, and were similar in treatment. It was decided to differentiate them by the color of the furniture, at the same time keeping the design the same, so that when large functions were given the three might be used together. Gray-green was the color chosen for the long room, yellow for one of the square rooms and red for the other.

The furniture itself was the most difficult problem.

The kind of furniture needed was that which should give a homelike appearance and suggest ease when the rooms were used as nurses' sitting rooms or for small parties; yet dignity and convenience were demanded at class and lecture hours. The solution was found in reed furniture. Bearing in mind the need of a support for notebooks or writing pads, all of the chairs were comfortable arm chairs. There were also seats and tables of various sizes and shapes that matched the chairs. A few low benches gave an added touch. The furniture is strongly made.

No cushions were provided for the chairs, partly because of the expense involved and partly because they seemed out of place in lecture rooms, but it seems likely that these



will be added, to give the room a final touch of comfort.

The lighting was given special attention. Several beautiful small chandeliers in bronze were secured at a low price from an old building. These add greatly to the charm of the rooms. They have their own switches. Other switches control small, soft lights set around them in the ceiling. By this means, either a brilliant or subdued light may be had.

With the hangings up and the furniture in place, came the "proof of the pudding." There had been much adverse criticism and even some scoffing at the possibility of alternating successfully such diverse affairs as lectures and parties. The lectures, with the chairs set in prim rows and the blackboards bare of draperies, went all right, except that the students had to grow accustomed to the suggestion of luxury given by the hangings and the cheery coloring of the rooms.

The real test was the first dance. A few palms, refreshment tables and screens changed the setting so that with an orchestra in the hall, soft lights and with the girls in dancing frocks, the transformation seemed complete and the arrangement was voted a success.

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THE increasing requirements in an X-ray machine due to the newer technics in more recent years, have served to bring about a greater appreciation of the Snook. While the number installed during 1927 far exceeded the records of previous years, the year 1928 saw the 1927 Snook record exceeded by 40%.



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How to Prepare Palatable Salt Poor and Low Protein Diets*

By BEULAH M. HULSEBUS
Presbyterian Hospital, New York City

ONE of the major problems confronting the physician and dietitian is the feeding of patients suffering from nephritis, hypertension or cardiac insufficiency. It is generally conceded that these patients should receive a diet low in salt and frequently low in its protein content.

Experience has repeatedly shown that food cooked without salt is more or less unpalatable and that it has been difficult to induce patients to accept such regimens. The usual criticisms offered by patients are, "Everything tastes too sweet," or, "It is tasteless." This naturally is a severe criticism in view of the fact that the patients for whom these diets are designed frequently have little desire for even the most palatable food. Preparing and serving the prescribed diets palatably and attractively is a problem. Since the lack of salt often presents a real hardship, the appearance of food and the manner of service become of paramount importance insofar as the psychological reaction of the patient is concerned.

The purpose of this article is to present certain deviations from the standard salt poor and low protein diets. It has been customary in the past to omit flavorings and extractives in view of possible resulting renal irritation. The medical staff of the Presbyterian Hospital, New York City, believes that any possible renal irritation is more than compensated for if the patient can be made, through the use of flavorings and mild seasonings, to take a diet adequate in calories to maintain his body weight. Failure of the patient to consume an adequate diet results in the loss of tissue protein and in a consequent increase in nitrogen that must be eliminated through the kidneys.

Planning the Daily Menu

In order to simplify the preparation of foodstuffs in the special diet kitchen, the menus for regular salt poor diets are so planned that by relatively simple readjustments they may be used for low protein diets. A regular salt poor diet can readily be changed into a low protein diet by reducing the meat and eggs and by limiting the bread and milk in the day's ration. For the purpose of definition it will be assumed that a salt poor low protein diet

is one containing between thirty and forty grams of protein and less than two grams of sodium chloride per day. On a low protein diet we allow half a portion of meat (about thirty grams), from a half to one pint of milk and from one to two eggs each day, one thin slice of bread with each meal and a cereal for breakfast. Legumes such as lima beans and peas are limited.

In planning the daily menu, fruit, cereal, toast, cream, butter and milk are given for breakfast. Sometimes lactose is added to cereal and fruit, and jelly may be given. It is especially desirable to include lactose in foods for low protein diets when a high caloric food consumption is necessary. For noon dinner a soup, one meat or meat substitute, potatoes, rice, macaroni, or noodles and two vegetables are given. However, if a cream soup, peas or lima beans, or a creamed vegetable are given, the dessert must necessarily be of fruit juice, fruit tapioca or some similar nonprotein and low salt content food. The cream soup does not necessarily influence the salt and protein content greatly since the recipes for creamed soup contain little or no milk.

Contrast of Flavors Important

For supper a main dish low in protein is given. This may consist of rice, macaroni, spaghetti or some vegetable. The regular salt poor diets usually include a salad. As often as possible the salad is prepared so that it may be incorporated in the soft diets. The dessert consists usually of a stewed fruit. Frequently a fruit juice drink or jelly is given to increase the caloric value and the attractiveness of the meal. Modifications of the regular salt poor menu necessary to make the meals appropriate for soft diets are the following: Meats are minced, vegetables are puréed, fruits containing seeds are omitted and when salads not appropriate for soft diets are used a puréed vegetable must be substituted.

Although the general rules of menu planning must be adhered to, it must be remembered that textures are not as important as contrast of flavors. In the following discussion we have tried to include certain of the procedures used in the preparation of foodstuffs that have proved to make our salt poor and low protein regimens at Presbyterian Hospital highly pleasing to the patient.

*Recipes for salt poor and low protein diets may be procured by writing to the department of nutrition, Presbyterian Hospital, New York City.

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It must be remembered that meats, milk, cereal, bread and cheese are high in salt and protein content while fruit and most vegetables are relatively low; menus, therefore, must necessarily contain more of the latter. Fruits are easily prepared, for salt is rarely added. A small amount of lemon or orange occasionally changes their flavor and often detracts from their sweetness which at times grows distasteful to the patient. Soups are undoubtedly the most difficult to prepare palatably. We rarely discard any water in which vegetables have been cooked. It is utilized in the soups in place of water or meat stock—this means water in which meat has been cooked without the addition of vegetables or seasonings—and small amounts of seasoning such as peppercorns, thyme, mace and the combination of a few drops of lemon juice with a piece of bay leaf are added. Cream diluted with water is substituted for a part or all of the milk. Small amounts of walnut paste are sometimes added to some mild cream soups. To some of the more tasteless vegetables, traces of lemon juice, nutmeg, mace or brown or white sugar are added. Some of these flavorings have also made spinach, carrots and other characteristically flavored vegetables more palatable. Great discretion must be exercised in the use of these seasonings because an excess may produce a result worse than no seasoning. As a general rule the combination of a mild vegetable with a strongly flavored one is adhered to. A sauce or relish is often served with vegetables. This may include a mild sweet pickled peach, pear, carrot or perhaps a tart baked apple or banana.

Stimulating the Patient's Interest

Meat is relatively easy to eat without salt. The minced meat used in soft diets is, however, more tasty and attractive if it is occasionally made into croquettes, meat loaf or meat balls. The addition of small amounts of puréed carrot, onion or a small amount of sage enhances its palatability. When preparing meat, green leaves of celery, a slice of onion, carrot, turnip, tomato or other vegetables may be cooked with it and removed from the meat before serving.

Macaroni, rice and spaghetti are so tasteless that it is advisable to serve some accompanying sauce or vegetable having a definite flavor. Tomato, béchamel, cream or Spanish sauces serve this purpose. Cream sauces are varied by the uses of small amounts of stock, tomato, celery, onion purée or a trace of curry powder. A combination of vegetables in diced or loaf form may be given. Apples baked or grilled with sweet or Irish potatoes are particularly satisfactory as supper dishes. Scalloped macaroni, potatoes, corn or other vegetables may be given. Cream and water is substituted for all or part of the milk used in scalloped dishes, and a few buttered crumbs with a sprinkle of paprika are used to add attractiveness and flavor.

Some salads appropriate for both soft and regular salt poor diets are those composed of stuffed prunes, plain fruit juice gelatines or gelatines with citrous fruits. Puréed vegetables or tomato tapioca may also be used. The lettuce is omitted for the soft diets, and sections of orange or grapefruit or some similar garnish is used to increase the attractiveness of the salad. Vegetables for salads should always be marinated in salt poor French dressing to which a small amount of sugar may occasionally be added. These salads may be served with a cream, boiled or mayonnaise dressing that may be varied and made more palatable by adding small amounts of very finely chopped salt poor sweet pickled carrots or beets, green pepper or tomato.

French dressings are varied by adding small amounts of very finely chopped parsley, green pepper, beets or egg. The preparation of fruit salads presents no particular dietetic problem. In warm weather a heavy salad such as potato, rice or spaghetti with pineapple juice dressing may be given to the regular diets in place of the main supper dish. A dainty sandwich may be served with the salads that form the main course of a meal. Occasionally plain, bran or fruit muffins replace the bread.

Desserts are relatively easy to prepare. Cornstarch is substituted for eggs and milk is replaced by cream diluted with water.

In addition to factors of taste the importance of the attractiveness of the tray has already been emphasized. The following methods are of great value in stimulating the appetite of the patient as well as making him interested in his food. Vegetables of different colors should be grouped in one meal. Slices of lemon are used to garnish spinach, and parsley or paprika is often served on potatoes. Uninteresting salads such as plain lettuce may be garnished with a strip of green or red pepper, a slice of carrot, beet or tomato or with a sprig of parsley. Colorless fruit salads may be made more attractive with a slice of red apple, a maraschino cherry, cubes of red fruit gelatine or some colorful fruit. Finely diced vegetables, tartare, tomato or cream sauces are served with meats and fish. Colored apples, mint jelly or some form of pickle may be given. If a colorless Bavarian cream is given, a thin layer of colored gelatine is put in the bottom of the mold so that when it is turned out the color is on the top. A small amount of whipped cream may be put on some desserts with a pastry tube. Some stewed fruits for supper are often accompanied with a small round unsalted cracker on which a bit of meringue and a bit of jelly have been arranged.

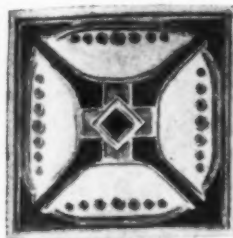
Variety in menu arrangement is important. Ingenuity on the part of the dietitian may, through the introduction of different and unusual dishes, stimulate true interest on the part of the patient who is compelled to remain on a salt poor régime for long periods of time. Failure of the patient to accept a salt poor and low protein régime signifies failure on the part of the dietitian either through her lack of the technique necessary to make food palatable, through her failure to prepare food pleasing to the eye or through her inability to present a varied menu.

Established Cases of Mental Disorder Are Well Treated in England

In respect to established cases of mental disorder, in no other country are arrangements as good as in England, according to Dr. E. Mapother, medical superintendent, Maudsley Hospital, London, in a discussion of the psychiatric clinic.

For the treatment of mental disorder there are four considerations, Dr. Mapother is quoted as saying in the *Journal of the American Medical Association*. These are: the ability of the patient to pay for his treatment, the severity of his malady, his willingness to receive treatment and the prognosis. At present the situation is dominated by the two first considerations.

Treatment of a mental disorder by a clinic at public expense may be obtained only when a patient has suicidal tendencies, or is a burden or a nuisance. The clinic should cover the widest possible range of cases, so long as the principle of voluntary treatment is not infringed.



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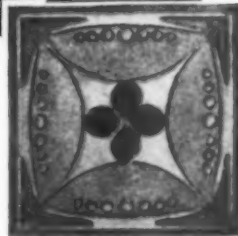
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Solving Help and Money Problems in the Food Department

By MARY W. NORTHROP

Dietitian, and

ELIZABETH BALDWIN

Formerly Assistant Dietitian, Montefiore Hospital, New York City

TWO problems that stand out at the present time as the chief difficulties in hospital food service departments are the problems of personnel and finances, or in other words, help and money.

Following the report of the section on administration of the American Dietetic Association on the first of these problems last Fall, it was decided that a further study of labor costs and labor turnover should be made in the food service departments of hospitals in New York City as the work of the New York Association of Dietitians this year. A committee was formed consisting of members of the association. This committee sent out 125 copies of a questionnaire covering personnel organization in the dietary department.

Only twenty-five of the hospitals to which the questionnaire was sent replied and only fifteen sent information that could be used. The report, therefore, does not contain enough figures to be representative of conditions in all hospitals. From it, however, may be drawn some conclusions as to the factors involved in labor turnover. This study and the similar one that was done simultaneously by the American Dietetic Association¹ may prove useful to other groups interested in the same problem.

New York Hospitals Are Studied

The hospitals represented by this report number fifteen with bed capacities ranging from eighty-two to 6,774. The mean bed capacity is 192 and the mean number of meals served per day is 1,000.² These hospitals are found in all parts of greater New York and include all types of hospital work and organization. In one hospital the steward manages all except special diet work; in another, the dietitian is in charge of food preparation and service and the steward acts only in the capacity of purchasing agent; in yet another, the dietitian is the purchasing agent and no steward is employed. There is not, however, a single instance of a dietary department in which the dietitian is completely responsible for all food purchasing, food preparation and food service to all patients and employees, unless it is the largest one of the group, the hospital of 6,774 beds. Here the one dietitian reports that she is responsible for all food preparation and service, including 912 special diets, and no mention is made of a steward's acting in any capacity. The name of the purchasing agent was not asked, so the information may be incomplete.

All except one of the hospitals reporting employ at least one dietitian. In all except three the dietitian is responsible for all food preparation in both the main kitchen and the special diet kitchen, and in the same number she is in charge of service of at least part of the

employees although in two cases the nurses' dining room is managed by the housekeeper or by the nursing department. Service to patients, however, is much less generally under the supervision of the dietitian. In only three out of the fifteen hospitals does she have charge of the services of food to all patients although she generally supervises the service of special diets.

Since the duties of the dietitian are so varied, the number of dietitians employed per hundred beds must vary also. In one case there was one dietitian for every sixty-five beds and in the case already mentioned, one dietitian for a hospital of 6,774 beds. These two extremes represent hospitals of very different types. The mean figure in this series was one dietitian for every 110 beds.

While costs were not primarily the subject of this study, it seemed expedient to determine whether high or low costs bore any relation to labor turnover. The following tabulation consequently was made from the information received in the questionnaires.

Raw food cost per person per day: average, \$.665; mean, \$.600; range, \$.455 to \$1.10.

Labor cost per meal: average, \$.0446; mean, \$.040; range, \$.034 to \$.078.

Labor time per meal served: average, .17 hours or 10 minutes; mean, .15 hours or 9 minutes; range, .11 to .28 hours or 6.5 to 17 minutes.

In order to be able to draw any conclusions as to the reasons for high labor turnover, it is necessary to compare labor organization and labor conditions in various hospitals. While there are many factors influencing the contentment of personnel that no tabulation can show, such as the location of the hospital, the construction of the kitchen, the personalities of the dietitian and the chef, it has seemed worth while to draw such inferences as we can from the material available in the questionnaire. The average amount of time spent in the preparation and service of each meal served, exclusive of the time of the dietitians and the steward, is ten minutes.

Analyzing the Situation in Each Hospital

Most of the kitchen employees are men and most of the helpers in the dining rooms are women. The working day ranges from eight to eleven hours, with a majority of hospitals showing a nine or ten-hour day. These hours are usually divided, and extend from about 6 a. m. to 6 p. m. The annual vacation for chefs and cooks is generally two weeks. For other employees, it ranges from one to two weeks. One hospital gives to all its employees a three weeks' vacation. One day off a week seems to be the figure most frequently repeated in the tabulation of time off duty, although there are several hospitals that give only half a day a week to their employees.

In general, chefs live out and other food service em-

¹ This study appeared in the March issue of THE MODERN HOSPITAL.

² The mean is taken in this report to mean the central figure in a series of figures.



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ployees are supplied full maintenance by the hospitals. The salaries of chefs vary almost in direct proportion to the size of the hospital, from \$100 to \$260 per month. Cooks are paid from \$65 to \$140; dishwashers, from \$45 to \$60; kitchen helpers, from \$40 to \$60; waiters and waitresses, from \$40 to \$60.

A tabulation of the average annual turnover for different types of employee follows: chefs, 175 per cent; cooks, 214 per cent; kitchen helpers, 278 per cent; waiters and waitresses, 609 per cent; average, 314 per cent.

As each of these figures is an average of the turnover rates of nine hospitals or less, the figures may not be an accurate indication of conditions that prevail throughout New York City.

In analyzing the situation in each of the hospitals from which the questionnaire was returned fully filled out, we find the following:

No. 1 is a hospital of 6,774 beds. The questionnaire was not filled out for all types of employees, thus making it impossible to determine the amount of time spent per meal served and the labor cost per meal. The labor turnover is 202 per cent, which is higher than the average for all the hospitals but lower than the figures for the other large hospitals in the group. The schedule of hours is given as ten to ten and a half per day, which is rather high, but fifteen days' vacation is given to all employees and their living conditions are apparently good. The hospital has one dietitian who is responsible for all preparation of food. Its size makes it impossible to make any fair comparison with the other hospitals in the group.

No. 2 is a small hospital. In 1927 it had no turnover in the food service department. It has no dietitian. The head cook is responsible to the superintendent. The dining rooms are run by the matron. In this hospital a ten-hour day prevails, with one day off a week and a three weeks' vacation. The labor time per meal served is eleven and a half minutes, which is a little above the average for all the hospitals. The labor cost is \$.034 a meal, the lowest of the group. This low cost is due to the absence of a dietitian and a steward and to low wages. Wage scales are not given in detail except for the cooks who receive from \$60 to \$80 monthly.

Labor Turnover Is High

No. 3 is another small hospital in which the labor time is very low, each meal served requiring only six minutes. A dietitian who is responsible for all preparation and service of food is employed. The labor turnover is only 65 per cent. Wages are about average and one day off is given each week. All employees live in, one or two in a room.

No. 4 has a turnover of 186 per cent. Since it is a large hospital this percentage is lower than in other comparable hospitals. The labor time and labor cost are both below the average, a remarkable record in view of the fact that half the patients are private patients and that all the employees are served by waitresses instead of by cafeteria service. The wages are rather below the average, and only one-half day off a week is allowed except to the chef and cooks.

No. 5 is a 200-bed hospital with a high labor cost, a high average labor time per meal served and a high labor turnover of 195 per cent a year. One dietitian is responsible for all food preparation, including ten special diets, and for food service to employees. Wages here fall within the usual limits, as do also hours, vacations and housing conditions. The only factor appearing in the questionnaire that could account for the higher turnover than

in No. 4 is the amount of ground the dietitian is forced to cover and probable consequent difficulty of supervision in the department.

No. 6 and No. 7 do not differ in any respect from the preceding cases and are therefore not noteworthy. No. 8 and No. 9, as the two hospitals having more than twice as high a rate of turnover as any others in the group are perhaps worth study. No. 8 is a hospital of 192 beds and serves 990 meals daily. Its per capita cost for raw food is \$.565 per day, which is near the mean figure for the group. It employs two dietitians who supervise all preparation and service of food, including service to the patients. Private patients, who average forty-five in number, are served by central service from a special kitchen. Ward patients are served on the ward. Their food is prepared in the main kitchen as is the food for all employees. Doctors and nurses are served by waiters or waitresses. Cafeteria service is used for the other employees. The labor cost per meal is \$.0662, which is with one exception the highest in the group.

Facts Worthy of Consideration

Labor hours are below the average, only seven minutes being consumed in the preparation and service of each meal. Wages are above the average. The lowest wage shown is \$60 per month. The cooks each receive \$100 a month, and the chef receives from \$150 to \$200 a month. The chef is the only employee who lives out. Perhaps the fact that the men employees other than cooks live sixteen in a room and the women employees live six in a room may have some bearing on the high rate of turnover, as may also the fact that although the chef and cooks work ten hours a day and the other employees from eight to nine hours a day, only half a day a week off duty is allowed to any employee.

No. 9 is a hospital of 585 beds. It serves nearly 3,000 meals daily. The labor cost per meal is \$.036, which is below both the average and the mean cost for the group. The labor time per meal is eight and a half minutes. This is less than the average but greater than that in hospital No. 8. The raw food cost is the lowest of any hospital in the group. This hospital has no private patients. Service to the patients is taken care of by the nursing service and is not under the supervision of the dietitian. Service is by waiter for the nurses, doctors and clerks, and cafeteria service is used in the other employees' dining rooms. Dietitians of whom there are six or an average of one dietitian for ninety-seven beds, are responsible for all food purchasing and food preparation and for the service of employees. Wages, except for the first cook and the chef, are lower than in some of the other hospitals in the group. Hours range from nine to ten, with one full day off each week. The annual vacation for the chef, the cooks and the bakers is two weeks. Other employees are given one week.

The turnover of waiters and ward pantrymen is particularly high, the turnover in the dining rooms being almost 1,000 per cent per year. Living conditions, as indicated by the number of men occupying each room, are good except in the case of the ward pantrymen. It seems probable that the low wages are a factor in this high turnover. The low labor time per meal served also indicates that probably there is a great deal of work to be done by each employee during his rather long hours.

No general conclusions can be drawn from a series of nine cases, and the factors influencing labor turnover are usually too subtle to be shown by the questionnaire method. Some of the following facts, however, do seem worthy of consideration:



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The forty-eight-hour week is advocated for efficiency of labor in industry. The average food service employee in these hospitals works fifty-eight hours. He also works on legal holidays.

Unskilled labor in industry receives more than thirty-nine cents an hour or \$18.72 for a forty-eight-hour week, which is the wage of our unskilled employees when we add \$50 a month for maintenance. Most of the employees under consideration are men.

The practice of housing employees rather than paying them enough for outside maintenance (88 per cent of these employees live in, and all of them presumably are given their meals) attracts to the work persons without the stabilizing effect of family ties. We house our employees two or more in a room. These room mates who are strangers to each other have no means of escaping from each other except by going out into the street.

A stigma is attached to kitchen work.

Food service is work that offers an annual opportunity for work in the country when the summer hotels open. No such opportunity for migration is offered to many other workers in industry.

Most hospital executives hire an applicant who looks reasonably clean and intelligent and who presents himself when there is a vacancy to be filled. This is usually done without much consideration of the applicant's fitness for the work.

Turnover figures compiled as these have been, by totaling the number of persons hired in each group of employees in a year, fail to take into consideration the fact that in many positions there is no turnover and that the apparent rate is increased by the constant change in other positions. Thus, in the hospital mentioned as having the highest turnover, the employees in half the positions in the department were unchanged during the year, the extremely high turnover, therefore, being made up of continuous replacements in the other positions.

More Persons Seek Advice at Tuberculosis Clinics

"There was a noticeable increase in 1928 of people coming for examination and treatment at the tuberculosis clinics throughout New York City," said Godias J. Drolet, statistician, Association of Tuberculosis Clinics in the City of New York, at the annual meeting.

"Among 28,962 admissions during 1928, 6,128 cases of tuberculosis were found. The remaining 22,834 examined included the adult and children contacts exposed to possible infection by the tuberculosis cases. They are examined regularly to prevent the further spread of infection."

The tuberculosis clinics in New York City include seventeen conducted by the department of health, four by the former department of Bellevue and Allied Hospitals and eight under private hospital or dispensary auspices.

"They already had 9,890 patients of all types under their care at the beginning of 1928, and the grand total treated during the year," said Mr. Drolet, "was 38,852, an increase of 1,275, or of 3 per cent, over the number treated by these institutions in 1927.

"The total attendance of old and new patients at the clinics in 1928 was 87,057. There was also a total of 58,291 nurses' visits in the homes or for clinic cases in 1928—an increase of 2,247, or of 4 per cent, over the number in 1927.

"Tuberculosis was more prevalent in New York City in 1928," said Mr. Drolet, "as 11,614 new cases were reported, compared with 10,873 in 1927 and the death rate rose from 86.1 to 88.6 per 100,000 population, or by 3 per cent; the highest mortality rate, 142.2, prevailed in the Borough of Manhattan. In Chicago, the tuberculosis death rate in 1928 was 85 and in Philadelphia, 82. In London, England, it is still 98."

The Duties of the Hospital Dietitian

The duties of the dietitian at the Alfred Hospital, Melbourne, Australia, as outlined in a recent issue of *The Alfred*, are as follows:

To direct the menus and supervise the preparation and service of all meals partaken in the hospital.

To keep a skilled check on, and exercise care of, all foodstuffs from the time when requisitions are placed until consumed or otherwise dealt with.

To pay special regard to the needs of each inmate with some margin of choice for patients' palates and for their physical condition at the time.

To ensure that special diets, whether for therapeutic or ordinary nutrient value, as ordered by a doctor, are carried out in minutest detail.

The demonstration of the preparation of special diets to special patients, giving reasons and general stimulus to such in and out-patients whose physical condition is either mainly or largely affected by diet. This applies especially to diabetic cases.

To keep an accurate and detailed record of all raw material supplied, and working through the accountant's department, check stores issued.

To ensure a continuous and close inspection of waste, not only through the garbage tin, but on returns from wards in order to determine that requisitions are reasonably accurate.

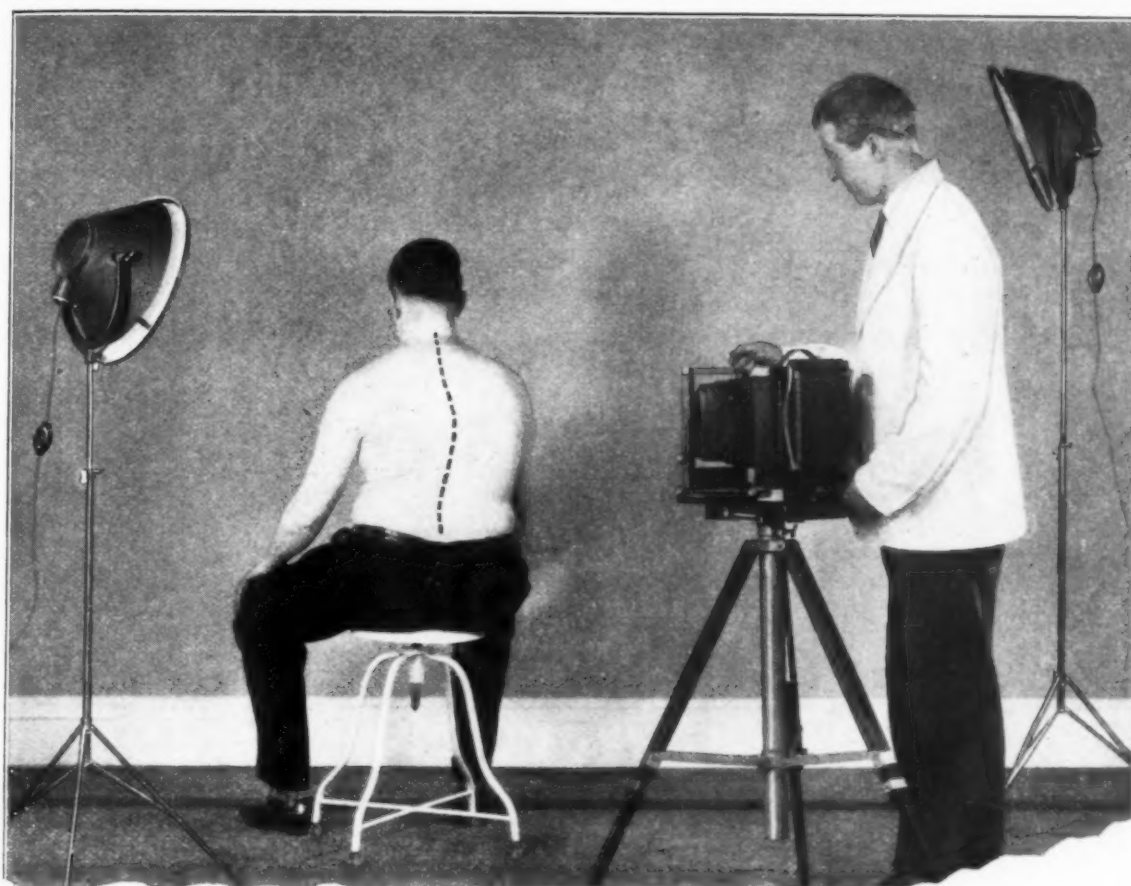
To exercise discrimination in regard to recovery of possible material that may be of direct use, or value if sold.

Compensating the Hospitals for Motor Accident Cases

A tax on each motor vehicle license to pay the hospital costs for patients hurt in motor accidents has been suggested by A. H. Teece, secretary, Melbourne Hospital, Melbourne, Australia, but the suggestion is opposed by C. Hodges, secretary, Royal Automobile Club of Victoria.

The tax would create a fund to pay the cost of maintaining every patient injured in a motor accident. Such a fund, Mr. Teece pointed out, could be administered by the Charities Board. In most cases, according to Mr. Teece, accident victims are compensated either by motorist, by workers' compensation or by insurance companies. When they leave the hospital all trace of them is lost, and the greatest sufferer from the deal is the hospital.

The question is exciting a great deal of interest everywhere, especially in the medical profession which, in public hospitals, is being called upon to do a great amount of work for victims of motor accidents without any special effort being made to recompense the hospitals or the medical men who give their services free in a majority of cases.



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OUT-PATIENT SERVICE

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A. K. HAYWOOD M.D., Superintendent, Montreal General Hospital, Montreal, Que

Prescribing for the Out-Patients at London Hospital*

THE London Hospital was founded in 1740. On September 23 of that year seven gentlemen met in the bar-parlor of the Feathers' Tavern, Cheapside, and decided to "begin the Charity on 100 Guineas." Two years later, a rule was made that certain diseases that were described as "unclean" should not be taken under the care of the hospital. It was agreed, however, that such cases might be treated but not admitted. This arrangement may be considered to be the origin of the modern out-patient department, though, of course, in time, all kinds of cases came to be treated as out-patients.

The present out-patient department of the London Hospital is a comparatively new department dating only from 1903. Prior to this, out-patients were seen in the basement of the main building of the hospital where the accommodation was inadequate to the increasing number of attendances and to the growing demands for more special departments.

The new department was built at a cost of £83,000. It was erected on a site some little distance from the main building of the hospital and this in itself is a drawback. It would be more convenient to have the department adjacent to the receiving room which is near the entrance to the hospital and where all patients are seen and classified on their first visit. It was, however, built on the nearest available site.

The planning of the building was restricted by the public streets on the north, east and south sides. The building consists of basement, ground floor, first floor, second floor and third floor and is connected to the main hospital by a foot subway under the street on the east side.

The out-patient department consists of two general departments, medicine and surgery and the special departments. Under the special department classification come obstetrics and gynecology, pediatrics, dermatology with which are associated the departments of actinotherapy and radiotherapy and the syphilis section of the department of venereal diseases, genito-urinary surgery with which is associated the gonorrhea section of the department of venereal diseases, orthopedic surgery, ear, nose and throat department, ophthalmic and dental departments and the department of physical medicine.

The general surgical and medical departments are in session every week day afternoon, the sessions opening at

1:30 o'clock. A session is supposed to last three hours but usually takes longer.

The special departments, with a few exceptions, sit in the mornings after 9 o'clock. In some instances, when there is not sufficient accommodation to afford space for each department to have its own set of rooms, two departments share rooms, and their sessions are made to dovetail. For instance, the orthopedic department and diseases of women department use the same set of rooms and are in session on alternate mornings.

Each Patient Is Card Indexed

The out-patient department is under the charge of the superintendent, a layman, who is responsible to the house governor of the hospital for the administration of the department. He is concerned with duties such as the registration of patients, and statistics. Under his supervision are an assistant superintendent, two inquiry officers and twenty registration clerks.

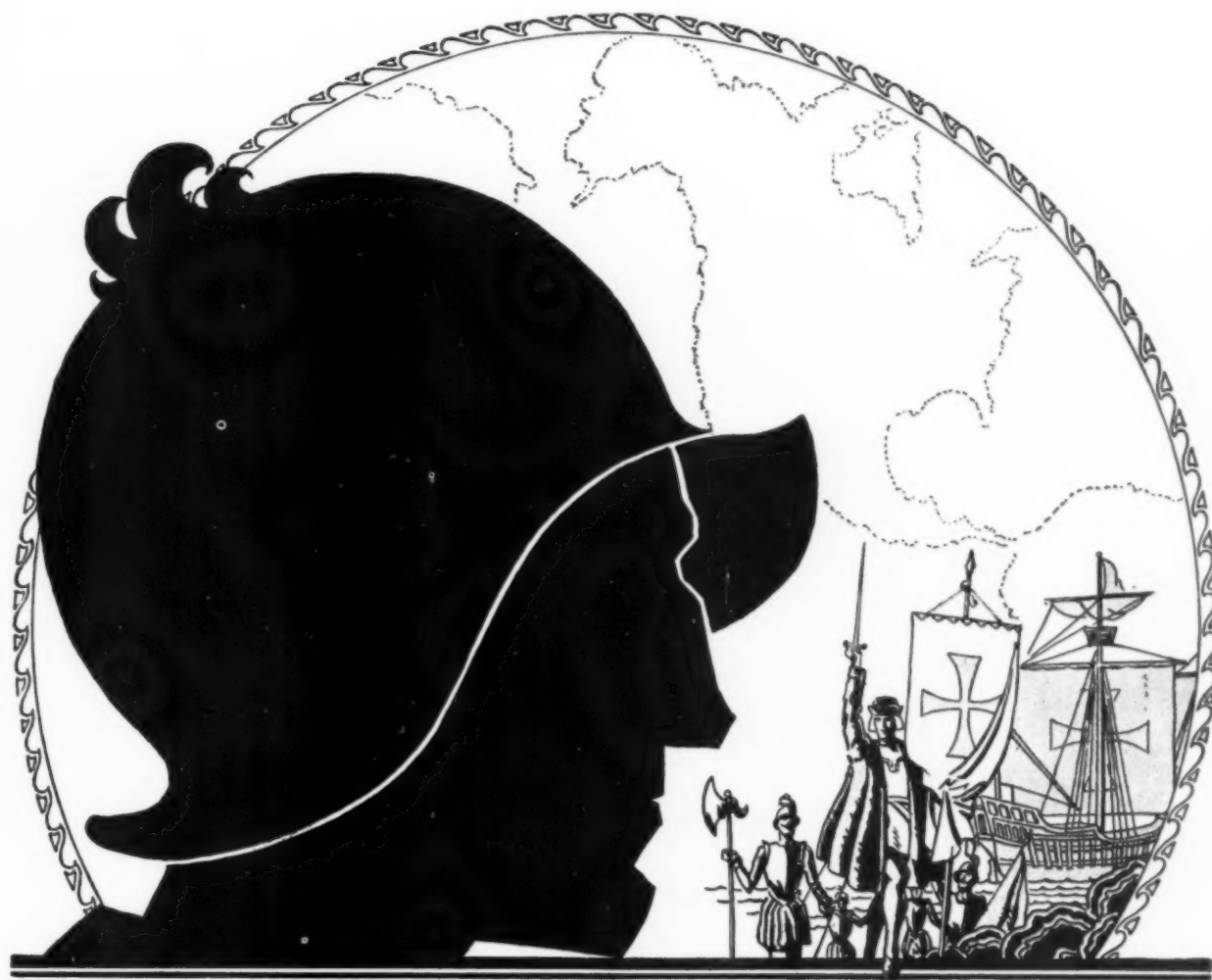
A card index is kept of all patients so that the record of any particular case can be quickly traced. Each patient is given a card on which are shown the name of the physician or surgeon under whom he is attending and his, the patient's, number. Should this case be lost, a reference to the card index will identify the case. The notes, or record of treatment, of each patient are contained in an aluminum cover and filed in racks according to the patient's number and under the name of his physician or surgeon. A patient is not allowed to take his notes away from the building. These are left behind and filed in the appropriate rack and reissued at the patient's next attendance on the presentation of his card. All these notes are preserved for three years. After that time, unless there are special reasons for keeping any particular notes, they are destroyed.

The process by which a patient arrives in the out-patient department is briefly as follows:

There is first a sieve called the receiving room to which an allusion has already been made and through which every patient who enters the hospital must pass. Here all patients are examined by the receiving room officer on duty at the time—a senior resident medical officer—and are classified into three groups¹: (1) The

*Abstract from an article on the Out-Patient Department of the London Hospital by Arthur W. M. Ellis, O.B.E., B.A., M.D., in the Eleventh Series of Methods and Problems of Medical Education published by the Rockefeller Foundation, New York, 1928.

¹The receiving room is open during the whole twenty-four hours. There are seven receiving room officers, two of whom are always on duty. Before holding this appointment a man is expected to have held the post either of house physician or house surgeon.



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Plants:

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Philadelphia, Pa.

Gretna, La.

minor ailment that is given one treatment and sent away; (2) the more serious case that is referred to the out-patient department for thorough examination; (3) the urgent case for which immediate admission as in-patient is recommended.

It is with the second group that we are now concerned. The receiving room officer having decided to refer the patient to the out-patient department, gives him a card admitting him to the next session suitable to his case such as the medical or surgical, the aural or ophthalmic. If the patient has visited the receiving room in the morning and is a medical case, the card will admit him to the medical session of that afternoon. The receiving room officer writes on the back of the card his diagnosis of the case. The patient takes the card to the out-patient building, and before seeing the doctor is interviewed by the inquiry officer whose duty it is to ascertain if the patient is eligible for charitable treatment. Inquiries are made as to earnings, regularity of work and the size of his family.

Working Men Are Given Preference

The patient is then given a treatment or prescription paper, bound in an aluminum case, and takes his place in the main hall to wait his turn to see the physician. After he is examined by the physician, he takes his prescription paper to the dispensary, gets his medicine, leaves his paper and goes away. A patient on his first visit is known as a new case. As he comes up for subsequent treatment, he is an old case. Only new cases have to pass the inquiry officer. Men are always seen first in order that they may not be unduly delayed in getting back to work.

Such is the mechanism for the admission of the ordinary patient coming to the hospital for advice. In addition to caring for such casual sick, the hospital acts in a consultative capacity for surrounding "panel" doctors, whose patients are insured under the state health insurance scheme, and for the medical officers of public authorities in the district such as school medical officers, tuberculosis officers and medical officers to welfare centers. If these doctors send their patients to the hospital with a letter giving a brief outline of the case they are advised in writing of the opinion of the attending physician or surgeon. Such patients are referred directly to the out-patient department. The number of such consultations in a year is unusually large since 35 per cent of the patients who attend come under the state health insurance scheme.

The out-patient department of the hospital has also large contractual obligations with state and municipal public bodies.

For the ministry of health it undertakes the conduct of the venereal diseases clinics for the surrounding districts, receiving in return a block grant of £8,500 per annum. In cooperation with the tuberculosis officers of the ministry of health it also undertakes the treatment of cases of tuberculosis of the skin referred by those officers.

With the London County Council the hospital has a contract to undertake the care of children referred by the school medical officers. The minimum number of cases receiving treatment by the terms of contract are: ophthalmic, 3,000 cases; aural, 2,400 cases; dental, 1,540 cases; ringworm, 100 cases. By the terms of the contract the London County Council pays to the hospital two shillings for each ophthalmic, aural and dental case and seven shillings and sixpence for each case of ringworm.

Extra sessions and cases are always paid for pro rata.

Patients who are able to do so, are expected to contribute towards the cost of their treatment, and the following charges are made: sixpence for each attendance, sixpence for medicine and dressings per week, two shillings and sixpence for a radiograph or x-ray treatment, and five shillings for an operation under an anesthetic.

The ministry of health makes per capital monetary grants towards the treatment of lupus and a block grant for the treatment of syphilis and gonorrhea. The London County Council makes monetary grants towards the treatment of school children with eye, ear, nose, throat and dental affections, and with ringworm.

New out-patients numbered 129,247, with a total out-patient attendance of 591,467. The annual expenditure for in-patients was £72,221 which made the average cost per attendance approximately one shilling and sixpence or about sixty cents.

For purposes of organization the department of medicine is divided into what are known as firms. There are five firms, four ordinary firms and the medical unit. An ordinary firm consists of an honorary physician, honorary assistant physician, a salaried, full-time first assistant and a house physician. The staff of the medical unit is salaried and full-time. It consists of a director, assistant director, first and second assistants, two house physicians and a number of attached workers engaged in research.

Each firm has its own wards and its own out-patient sessions. Patients admitted from the out-patient session of any firm go into the beds of that firm except in cases of emergency.

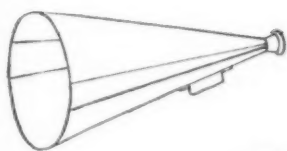
Two firms hold medical sessions daily in the out-patient department. Each firm has its own suite of waiting and examining rooms and the cases attending are divided equally between them. Each firm is represented by the assistant physician and first assistant and is assisted by a receiving room officer, whose duties include attendance in the out-patient department, and a clinical assistant, a junior non-resident medical officer doing his appointment in the hospital. One firm is responsible for the out-patient teaching on each day. Each firm has, therefore, one teaching and one nonteaching day a week. The medical unit has its out-patient sessions just as any other firm.

Departments Use Similar Systems

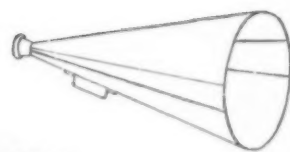
It is the custom for the physician to begin his afternoon's work by quickly examining the new patients who have been prepared for his inspection. From these, he selects those whom he wishes to treat himself, such as obscure cases, good cases for teaching purposes and cases that have been sent to him especially by some outside practitioner or public authority. Those cases that he feels can be adequately dealt with by his assistants, he delegates to them. An assistant may always consult the physician if he is in need of advice on any particular case. Advice in writing is sent to all outside doctors who refer their patients to hospitals for an opinion.

Much the same system, with minor differences, is carried out in the surgical out-patient department. On the surgical side there are four clinical assistants as compared with two on the medical side.

The department of pediatrics has only come into existence within the last year. Out-patient sessions are held on three days a week, on Tuesdays and Fridays for new patients and a certain selected number of old ones and on Wednesdays for old patients only. Work is begun on



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accumulates in corridors

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In this corridor of the Illinois General Hospital, Chicago, Ill., Architects, Schmidt, Gardner & Erickson, J-M Acoustical Correction has minimized echoing and reverberation.

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engineers can reduce corridor
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those days at 9:30 a.m. and continues until about 1 p.m. The number of patients attending is variable depending on the time of year and on the weather, but sixteen to eighteen new patients and twenty to thirty old ones on each Tuesday and Friday and seventy to eighty old ones on each Wednesday would represent the average attendance. As this department has only been at work for a year, the number of patients attending naturally shows a tendency to increase and at the present time the question as to whether the department should be open on one more morning a week is receiving consideration.

Children are treated in this department from the time of birth up to the age of twelve. Cases admitted fall into three groups. In the first are all those cases referred to the department from other parts of the hospital. They include the casual sick child brought to the receiving room of the hospital and then referred to the pediatrics department for treatment as well as any case that any other department, such as the aural or skin departments, considers to be in need of advice and treatment. In the second group are included all those cases referred directly to the department by the surrounding infant welfare centers. These centers have for their object the giving of advice in mothercraft and infant feeding. Their patients are babies in good health. Should any of these infants fall ill they are referred directly to the pediatrics department by the medical officers in charge of the welfare center.

A reciprocal arrangement exists also in that when infants who have been attending the children's department are considered to be well they are referred back to the welfare center with a note as to their diet and the treatment they have received. This arrangement is an entirely voluntary one and it is apparently working well.

Children's Work Is Considered Important

In the third group are included the children of school age who have been referred by the officers of the school medical service for advice and treatment. These children, under an arrangement made with the chief school medical officer of the district, are referred directly to the department and their school medical cards are sent also. After examination, the opinion of the member of the department examining the child is entered on the medical card for the information of the school doctors and in this way a considerable amount of information useful both to the school doctors and to the department is recorded. The London County Council, under whom these school doctors work, materially assists the work in the department by sending an organizer who is responsible for the medical cards of each child.

Probably two-thirds or more of the children seen at each session come from the welfare centers and the school doctors, the department thus acting as a consultative center where also treatment may be obtained. It may be stated that it is the aim of the department to foster this side of its activities since it is believed that there is nothing more important than this cooperation between outside services and the hospital itself. The department at present acts in this consultative capacity to school medical officers who are responsible for no less than 70,000 school children.

On Wednesdays, which is the day on which old patients attend, the appointment system is in force. Mothers with their children are given a definite time to attend, usually some particular time between 9:30 a.m. and 12:30 p.m. Each patient is seen within half an hour of his arrival and in this way long waiting on one day in the week is to some extent obviated.

The staff of the department of pediatrics consists of one physician on the honorary staff who is head of the department, one full-time assistant, one part-time assistant, one honorary assistant and the house physician to the department. On the nursing side two Sisters, three nurses and several voluntary workers are employed, and one of the two Sisters also does some visiting at the homes of the patients. Apart from the services given by the Sisters there is no system of social service that is so common in the United States. It is almost always possible, however, to obtain some information about patients when necessary by the official health visitors of the surrounding municipal bodies.

A Letter From London

The following letter has been received by the editor of THE MODERN HOSPITAL, from Dr. H. L. Eason, Guy's Hospital, London:

"My dear Sir:

"As one of the editorial consultants of THE MODERN HOSPITAL, I feel I ought to call your attention to what is apparently a misapprehension as to facts in a paragraph on page 142 of the January number of THE MODERN HOSPITAL, which states that women anesthetists in England must be registered physicians.

"In this paragraph it is stated that it is strictly illegal for any person other than a registered practitioner to give an anesthetic in England. This is not true. It is not illegal for any unregistered person to practice medicine or surgery in England. The sole duty of the General Medical Council, which was established by an Act of Parliament in 1858, is to keep a register of duly qualified practitioners in order that persons requiring medical aid may be enabled to distinguish between a qualified and an unqualified practitioner.

"It is illegal for an unregistered person to practice as a dentist or a midwife, but the anomaly of the law is such that it is not illegal for an unregistered person to practice medicine or surgery.

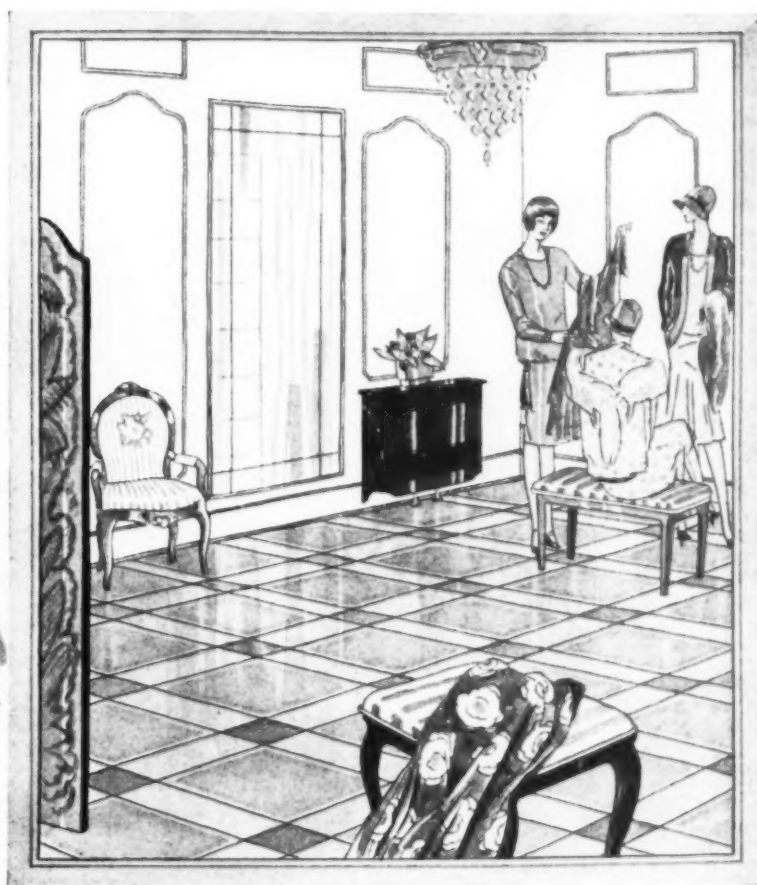
"Similarly it is not illegal for any unregistered person to give an anesthetic, but if an unregistered person does give an anesthetic and the patient dies under the anesthetic, a coroner's inquest must be held, as it is held in every case of death under anesthesia, whether it is given by a registered practitioner or not. As the result of a coroner's inquest, an unregistered person who has been responsible for a death under an anesthetic may have to face a trial for manslaughter."

Gift Provides for Metabolic Clinic at Carmel

Through an endowment of \$200,000 for building costs and ample provisions to cover maintenance and operation, a completely equipped laboratory and research building is being built at Carmel, Calif.

According to the *Journal of the American Medical Association*, the object of the new project is to increase the knowledge of metabolic diseases and to provide facilities for diagnosis and treatment. Beds for twenty-five patients will be provided in the new building.

Funds for the project are being provided by Mrs. Grace V. Harris. Dr. Rudolph A. Kocher, formerly of the Hooper Foundation, University of California, is to be medical director of the institution.



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THE Wall Cabinet Heater — built only by Modine—conforms to the most exacting demands of modern room decoration, but its cost makes it the most economical installation where utility is the prime consideration.

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Send for your copy of our new 4-color Booklet "Modine Cabinet Heaters". In addition to construction details and capacity details, it has numerous suggestions for Modine Cabinet Heaters in the decorative scheme.

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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and
Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

Modernizing the Heating Plant in the Hospital

OF ALL the problems confronting hospital engineers, perhaps none has been so much discussed and so little acted upon as the problem of modernizing the hospital heating plant.

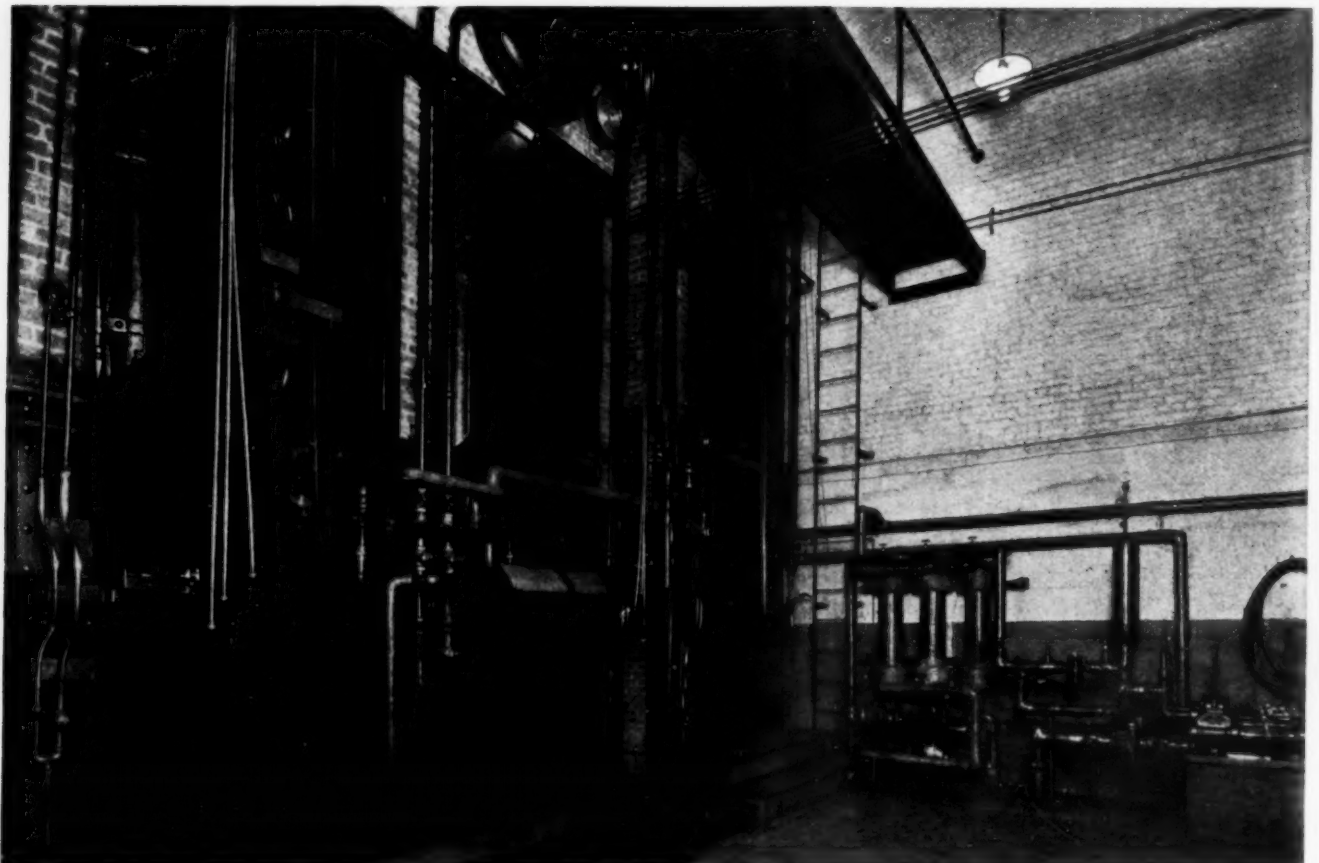
Operating rooms have been rebuilt and newly equipped. Kitchens have been made to conform with every modern requirement. Laboratories have been filled with the latest and most intricate apparatus that science has evolved. In contrast to these improvements, the heating plant in many cases remains the same antiquated, inefficient and insanitary system of twenty-five years ago.

The growing list of hospitals, asylums and similar in-

stitutions that have recently installed oil heating equipment has again brought to the fore the question, "Will liquid fuel solve the hospital's heating problem?"

That the answer is in the affirmative has already been proved by hundreds of hospitals throughout the country. The installation of oil heating equipment has brought the following improvements which, from the hospital point of view, are the principal points involved:

1. Elimination of the noise and confusion resulting from coal deliveries and ash removals. In an institution where quiet is often imperative, the roar of coal sliding down sheet iron chutes into the coal bins and the banging



A view of the oil burners and boilers used in the Hospital for Joint Diseases, New York City.

The day of better things in hospitals

Better buildings, better furnishings, better equipment — everything connected with hospitals is getting better in both quality and style.

In hospitals everywhere there is a growing appreciation of the advantages of pleasant, home-like surroundings and the beneficial effects of harmonious color combinations.

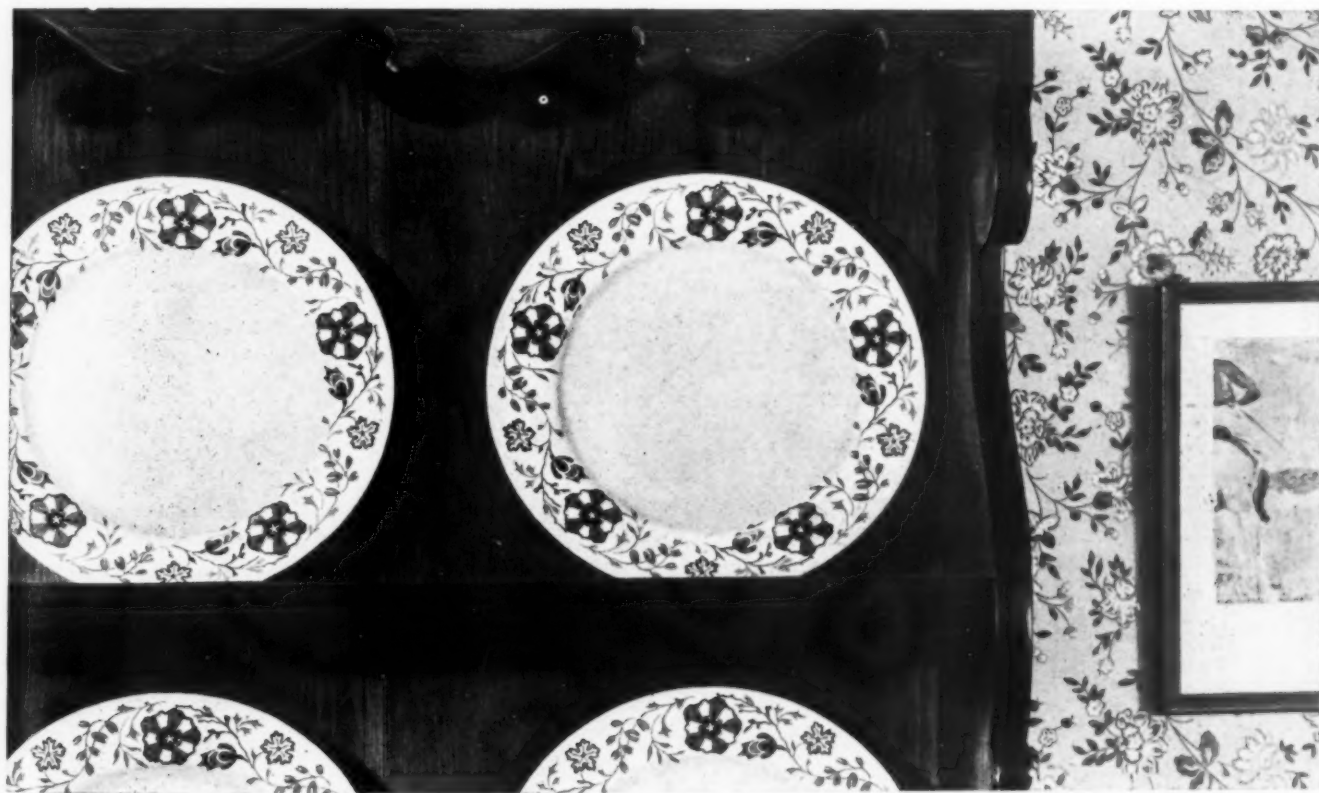
The progressive superintendent and dietitian cannot fail to recognize these signs of the times. And one of the most important things they can do is to have more colorful and better designed china for both patients and personnel.

Syracuse China with its wonderful Old Ivory body, its many new patterns and unusual color effects offers the logical way to take this important step.

Over a period of many years Syracuse China has established and maintained its style leadership. The Onondaga Pottery Company has pioneered in originating and perfecting new ideas in institutional china.

Old Ivory Syracuse China with its added style, beauty and attractiveness loses none of the practical, durable and needed qualities for which this china has always been favorably known and satisfactorily used. Onondaga Pottery Company, Syracuse, N. Y.

Old Ivory



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In the Best Interests of Competent Pathological Service

Routine tissue examinations and general consultation work on tissues for your hospital can be given the highest of authoritative quality.

THE service of the National Pathological Laboratories is reliable as it is thorough, and competent as it is authoritative. Those hospitals which do not have the facilities of a laboratory or the service of a pathologist can here establish a dependable contact for routine tissue examinations.

In fact, in the larger field of consultation work on tissues for hospitals in general, the ability of the National Pathological Laboratories to render accurate diagnosis is broadly acknowledged throughout the profession. A staff of five pathologists, headed by Dr. Ludvig Hektoen and Dr. Josiah J. Moore is at all times available.

For expedience, reports can be made promptly by special delivery, so that the element of time in such work is not a serious interference with the best of laboratory service.

Beyond tissue diagnosis, all important laboratory examinations are made, including—

**Wassermann and Kahn Tests,
Blood Chemistry, Bacteriology
and Chemical Pathology.
Also X-Ray Consultation
by Dr. Ed. S. Blaine**

The National Pathological Laboratories have membership in the A. H. A. They are approved by the A. M. A. and A. C. S., as well as by other approving and standardizing bodies.

If you have not received a copy of our recent booklet, "Diagnostic Aids," write for one today.

**NATIONAL PATHOLOGICAL
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55 East Washington Street
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of ash cans upon concrete floors present a difficult situation with which authorities must contend.

2. Improvement of sanitary conditions by doing away with the dirt, ashes and dust incidental to coal burning. Cleanliness must be maintained throughout hospital buildings. A dirty boiler room, with the dust of coal and ashes filling the air, threatens the health conditions of the entire institution.

3. Smoke abatement. Every hospital recognizes the importance of keeping the air free from unhealthy smoke.

4. Assurance of an even and easily regulated source of heat. Sudden changes of weather must be met with instant regulation of the hospital heating plant. A system that is slow to respond may bring about hours of discomfort for the occupants of the building.

Since the delivery of liquid fuel consists merely of a quiet piping from the fuel truck to storage tank, the



This is the oil heating plant at the Free Hospital for Women, Boston.

noise of replenishing the fuel supply is abolished with the installation of oil heat. Oil makes no ashes, so the ash removal problem is completely eliminated.

With oil heat the boiler room may be kept spotlessly clean. The dirt and dust of the basement are gone. The space formerly occupied by coal bins can be used for storage or other purposes, and the cellar can be made to conform with the strictest sanitary requirements.

The fact that oil burns without smoke or soot in a properly regulated burner has solved the smoke abatement problem in many towns and cities. The hospital fire hazard is also reduced by the absence of soot and sparks in oil burners. Seventy-five per cent of fires are caused, according to the Chicago Fire Underwriters' Association, by sparks and soot in the chimneys of buildings.

Because oil heat is produced by a flexible flame, doing away with the necessity of stoking, building and banking of fires, it makes possible uniform temperatures, automatically controlled. The furnace responds immediately to outside changes in temperature. The sudden arrival of chilly weather is met by a furnace running full blast. A warm spell shuts off and immediately stops the consumption of fuel. Thus, the adoption of oil equipment not only remedies the prime evils of old-fashioned heating plants, but it often effects actual economies in the operation of the plant.

MIDLAND LOHADOR LIQUID SOAP DISPENSERS

The latest development in liquid soap dispensers. Elimination of unnecessary working parts has made the Lohador Dispenser trouble free and sure acting at all times.

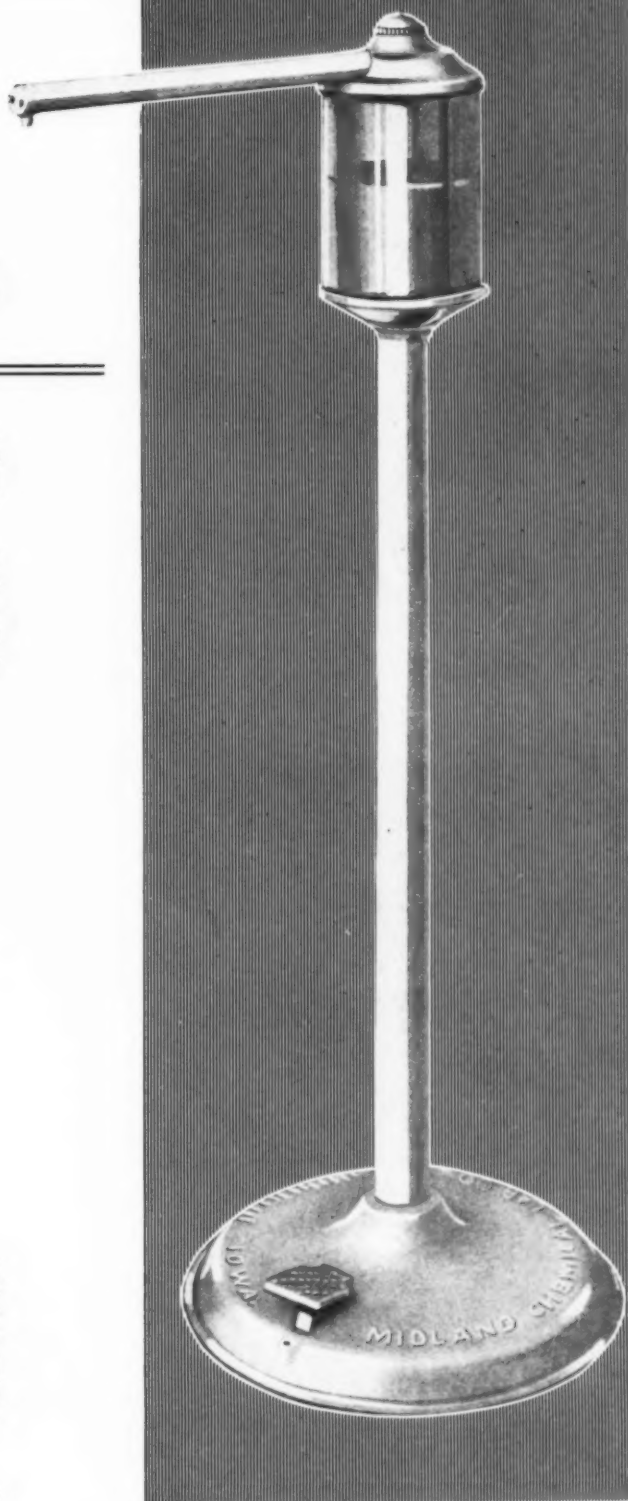
Non-corrosive metals used in the assembly assure a free, full flow without danger of clogging. Perfectly balanced, the Lohador Dispenser will not tip over yet it is light enough to be easily moved from place to place. White enamel and heavy nickel finish.



TRAY TYPE

The BABY LOHADOR Tray Type DISPENSER shown above is the ideal equipment for nursery and all uses that require the soap to be carried from room to room. The same care in building the tray dispenser has been followed as in the foot pedal. Positive trouble free and continuous service is to be had with this equipment.

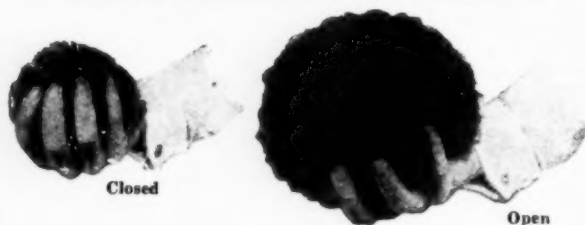
Write Midland regarding the free use of this modern equipment.



FOOT PEDAL TYPE

MIDLAND CHEMICAL LABORATORIES, INC.
DUBUQUE, IOWA

CURLED HAIR



Versus

SUBSTITUTES



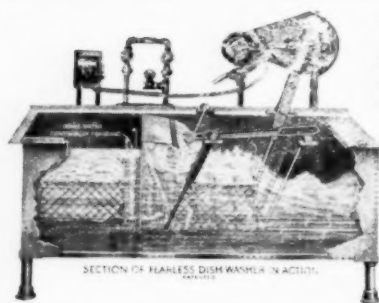
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EXPRESSLY
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SAMPLES CHEERFULLY FURNISHED

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Sterilized Curled Hair

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FEARLESS DISH- WASHER SYSTEM

Many Hospital authorities claim they are never assured of complete sterilization of their dishes by any other machine than the FEARLESS.

A simple statement of your wants, including number of patients fed and space available for machine, will bring you our plan and price without obligation.

Maybe our SUPER-SPRAY Type would suit your needs best, either in single or CONVEYER Unit. Rest assured we can meet your needs perfectly and most reasonably. Ask your Supply House and write us for folders.

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What Can't Be Overlooked By HOSPITALS

catering to special diseases is the thorough wash action and boiling hot rinse

The Barnert Memorial Hospital, Paterson, N. J., reports that its oil burning equipment has resulted in an annual saving of more than \$1,500 in heating expenses. While conditions in every institution naturally differ, the advantages of liquid fuel as shown by its use in this New Jersey hospital may be taken as fairly typical of the hospital class.

In operating economy, for instance, the Barnert Hospital shows the following comparison of costs in the use of coal and oil:

Cost of Heating With Coal

4 tons daily at \$6.25 per ton.....	\$175.00 weekly
2 men at \$3.33 daily.....	46.32 "
1 man at \$5.00 daily.....	35.00 "

Total for the week.....\$256.62

Cost of Heating With Oil

600 gallons daily at \$0.04 per gallon.....	\$168.00 weekly
1 man at \$3.33 daily.....	23.31 "
1 man at \$5.00 daily.....	35.00 "

Total for the week.....\$226.31

Weekly saving through use of fuel oil.....\$30.31

Annual saving through use of fuel oil..\$1,576.12

Aside from economy, the Barnert Hospital has found that the outstanding advantages of oil burning are its cleanliness and the elimination of noise.

"By burning oil," says Dr. Louis Hollander, superintendent, "we find that we have a cleaner and neater institution and at no time are we burdened with a continuous noise of hauling ashes out of our boiler room and having coal put in the pockets. This, in itself, is quite an item at our place."

The fuel tank for this institution has been placed under the ambulance driveway at the rear of the hospital. Here it is out of sight, easily accessible by fuel delivery trucks, and it leaves the cellar space formerly occupied by coal bins free for storage or whatever use the superintendent wishes to make of it.

Settling the Waste Disposal Problem

The oil is brought from the storage tank to the burner by two special pump sets. A coil heater raises the temperature of the fuel oil from the 70 degrees maintained in the tank to 100 degrees before burning, a step calculated to perfect the atomization process.

Disposal of waste by burning presented a problem to be settled by the installing engineers. It was necessary that an adequate incinerator be included in the equipment to supplement the existing waste disposal apparatus.

The matter was settled by selecting an oil burner mounted on a specially constructed tile lined door. It is so arranged that the whole mechanism may be swung away from the front of the furnace. An opening of about two and one-half feet is left clear to enable the attendant to kindle a fire, burn the refuse and clean out the ashes with the utmost ease. The burner, swung back into place, is then ready for operation. This not only simplifies the problem of waste disposal but it also makes the burner easily accessible for inspection.

Among the other hospitals that have turned to oil as the solution of their heating problems are the Boston City Hospital, Boston; San Francisco Hospital, San Francisco; Austin Hospital, Chicago; Kentucky Baptist Hospital, Louisville, Ky.; Hospital for Joint Diseases, New York City; Children's Hospital, Akron, Ohio; Morningside Hospital, Portland, Ore.; Memorial Hospital, Pawtucket, R. I.;

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now covering 44 States in a gratifying manner—Uniforming to specifications, eliminates hospital detail which is a feature not overlooked by leading hospitals

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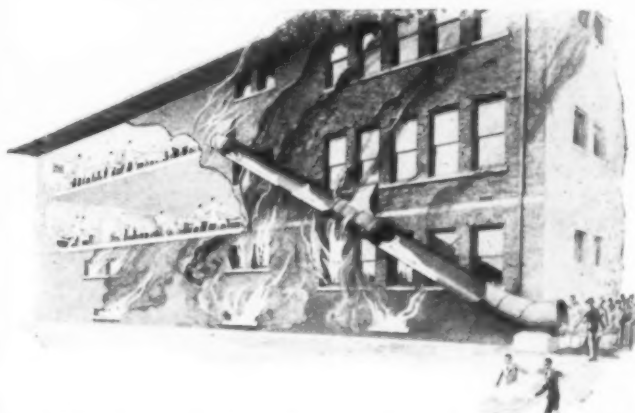
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happened in your hospital could you meet relatives and friends and say—

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Write for Details and Specifications; also list of Hospitals now equipped.

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"My! What Delicious Soup" "Yes, and Nourishing, Too"

For invalids and convalescents on liquid and semi-liquid diets, you need a variety of appetizing and nourishing foods. You will find constant use for both of these Soups:

SPRENGER'S

Best-O-Pea and Best-O-Bean

These delicious Soups are made from the choicest peas and beans in a sanitary modern plant. All the freshness and flavor of these vegetables are preserved intact. They come in dry powdered form, needing only the addition of water and a few minutes' Boiling to prepare them for serving.

SPRENGER'S Barley is also used in modern hospitals, especially for modifying cow's milk so as to make it suitable for infants.

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Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Plate Flatware.

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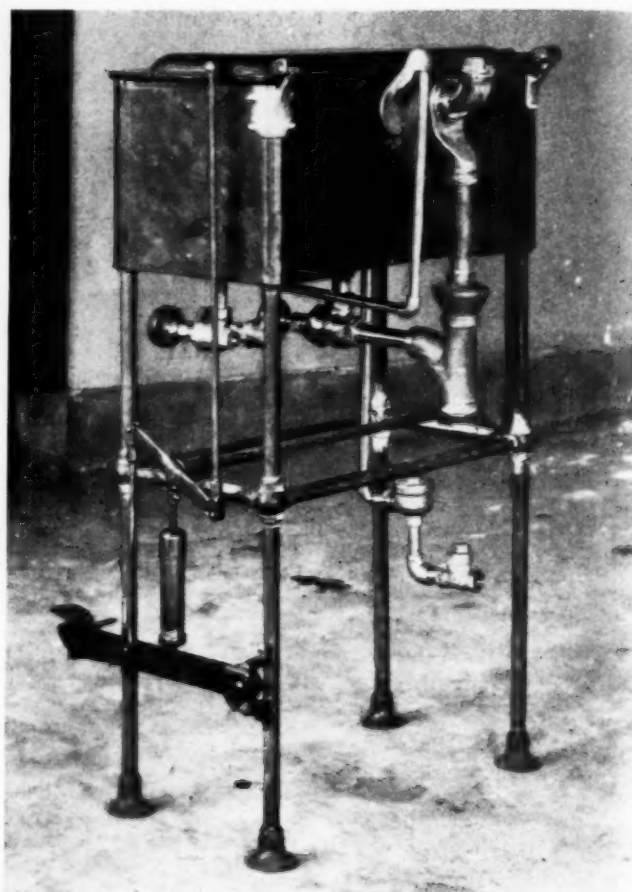
Soniat Mercy Hospital, New Orleans; St. Luke's Hospital, Newburgh, N. Y.; Johns Hopkins University Hospitals, Baltimore, and the Missouri Methodist Hospital, St. Joseph, Mo.

The fact that new names are constantly being added to this list shows that liquid fuel has gone a long way toward solving the hospital heating problem. Oil heating has come into its own. It has been proved to have many advantages over solid fuel. No institution needs to make use of these advantages more than does the hospital. Where health is concerned every unit of equipment must be up-to-date and efficient.

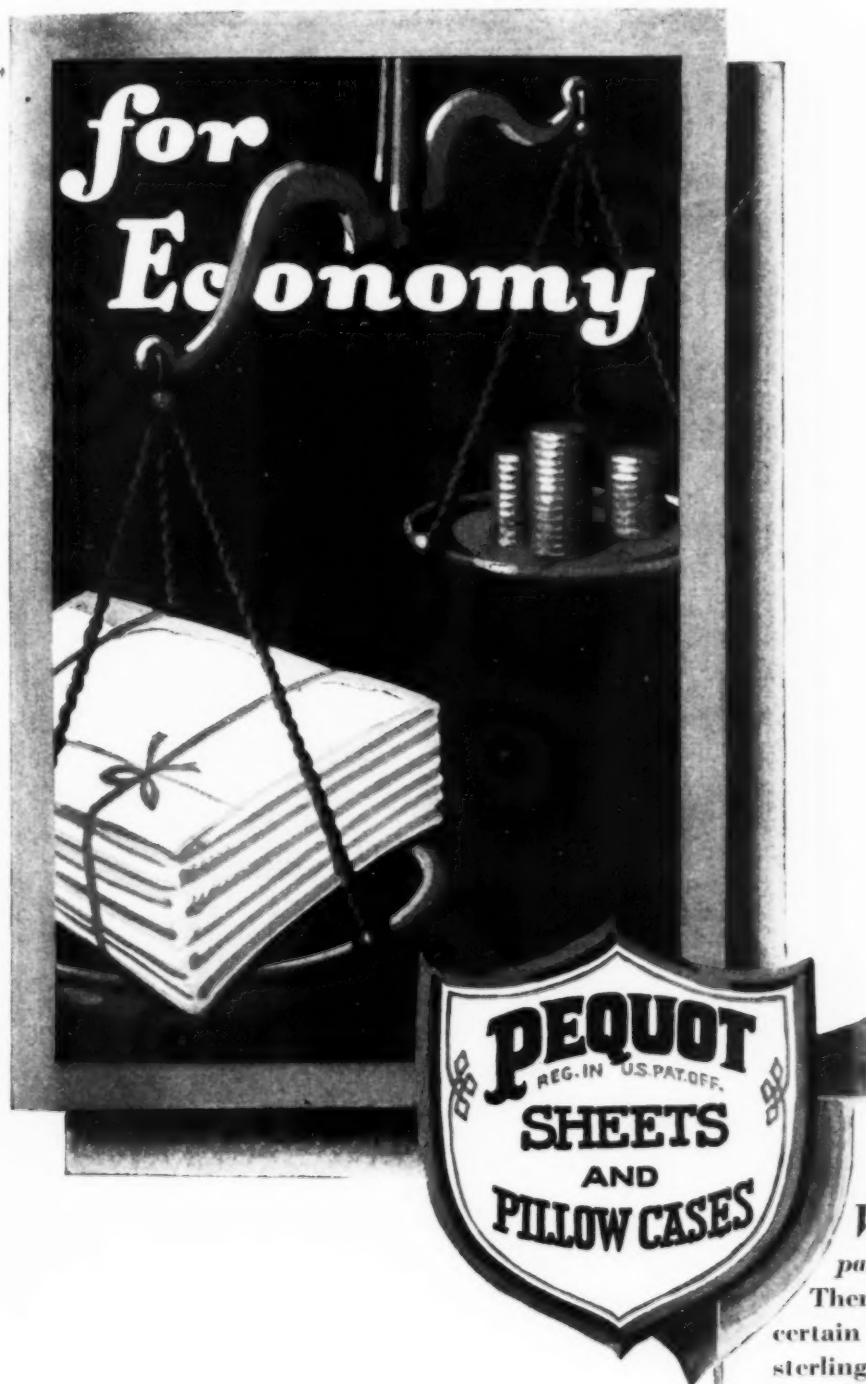
New Filling and Waste Connections for Sterilizers

Methods in general use for connecting water filling and waste piping to sterilizers have been the subjects of widespread discussion during the last few months.

In the older types of nonpressure sterilizers for instruments and utensils of all makes, where the water connections have been at the bottom of the sterilizers, it is claimed that a sudden drainage of the water feed pipe in the basement—a frequent occurrence—might result in



draining back into the supply line the contents of a sterilizer in the process of filling. Then later this same water might be drawn from a drinking fountain or any other tap in the system. Such occurrences would not happen with pressure sterilizers because the water in them never comes into contact with unsterile substances and therefore is not contaminated.



Weigh . . . test . . . compare . . . examine!

Then you will be more certain than ever about the sterling strength of Pequot Sheets—the firm fabric of strong flawless threads that makes them wear and wear!

Pequot's uniform durability means true economy.

Pequot is America's most popular sheet.

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—this dish is a favorite

Cream of Wheat with Hidden Peaches

Cook $\frac{1}{4}$ cup Cream of Wheat for one hour in 1 cup boiling water, in the top of a double boiler. Add $\frac{1}{2}$ cup chopped canned peaches. Mix well and serve hot with cream, as a cereal, or chilled and molded, as a light dessert.

THE Dietitian of a well known hospital, just outside Chicago, is often complimented on her ingenuity in serving this clever dish. It delights child patients and proves tempting to adult convalescents as well. Simple and economical to make, and ideally suited to impaired digestions and appetites in need of reviving.

In combination with the pleasant, refreshing peach taste is that good old stand-by of practically every hospital in the land—Cream of Wheat. Its bland and delicate flavor is the perfect one to blend with a wide variety of other foods. Its simple, granular form can be handled without tax by the weakened digestions left in the wake of a large number of diseases. And the high carbohydrate content of Cream of Wheat abundantly supplies the nourishment doctors want their patients to have.

Dietitians and nurses know the value of a little element of surprise in combating the routine of hospital menus. That is why they are quick to welcome the ingenuity of just such easy, ready-at-hand dishes. And leading doctors everywhere approve the liberal use of Cream of Wheat in their patients' dietaries.

The triple-wrapped-and-sealed Cream of Wheat carton means a fresh supply always ready on the shelf—absolutely free from contamination. There are many delicious ways of serving this standard food. Ask for the free booklet, "50 Ways of Serving Cream of Wheat," for suggestions that you'll like.

FOR THIRTY TWO YEARS A STANDARD
FOOD ON PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

It is also claimed that under certain conditions any pressure sterilizer might in cooling create a considerable degree of vacuum that would suck the impurities of the drainage system back into the sterilizer, provided there was a direct closed pipe connection between the sterilizer and the drainage system and a leaky valve. It is further claimed that any backing up or clogging of drainage might actually permit a back pressure that would tend to force drainage matter into any sterilizer having a closed connection to the waste.

Human Element Figures in Accidents

It is not intended to infer that any of these adverse conditions occur frequently or that they need to occur at all in any hospital where valves are maintained perfectly tight and in good functioning condition, and where well defined regulations are precisely followed. The point emphasized is that human frailties are responsible for the majority of accidents and errors of technique in the handling of all apparatus, and that definite safety provisions for the avoidance of errors are highly desirable in all hospitals.

One of the well known sterilizer manufacturers has recently completed a series of interesting and exhaustive experiments and tests that throw light on these problems and pave the way to safer performance. Still further elimination has been made of that bugbear, the human element, from the operation of the sterilizers.

As an introduction to this investigation, an ordinary one-inch pipe was extended from the second story of a building to the basement. A "U" tube was attached to the top and the pipe filled with water. Sudden drainage of the pipe created a vacuum of fifteen inches of mercury as measured by the "U" tube—half the value of a perfect vacuum.

This test corresponds to the action of an ordinary water pipe, leading to a sterilizer, as it is suddenly drained in the basement by a mechanic about to make repairs. It also indicates the need of a filling device that under the most exaggerated conditions will prevent the withdrawal of water from nonpressure sterilizers into the water supply piping. Any true safety provision must evade any direct unbroken water connection to the sterilizer, even though the filling is made at the top of the reservoir, since the reservoir might be filled to the extreme top by stoppage or by the omission of an overflow vent.

In tests leading up to the introduction of the apparatus described in this article, by comparatively low vacuum in the supply piping water was lifted as high as ten inches above the water level in the sterilizer by an imperfectly air vented connection to the sterilizer.

How the Device Works

The new device offered makes use of an air vented connection. The sterilizers are filled from a tube slightly above the sterilizer and leading into a baffled opening at the back. This tube contains no socket or trap from which contamination of the contents of the sterilizer might result. It is claimed that a sustained vacuum of nearly thirty inches, as close to perfect vacuum as is possible, fails to withdraw any water even when the sterilizer is filled to overflowing. The air break in the filling tube is so designed that no water escapes from it in filling. On the contrary, air is sucked into the filling tube when it is in operation.

To avoid any contamination of surgical sterilizers, either pressure or nonpressure from the waste or drainage system, each sterilizer made by this manufacturer is



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Three generations of experience—acre after acre of floor space—our own forests, mills, veneer plants, etc.—enable us to produce this masterfully designed, beautifully finished line of hospital furniture at a price that compares favorably with the ordinary.

Hill-Rom Hospital Furniture is sturdily constructed of selected woods and handsomely finished with the most durable of materials to withstand constant hard usage.

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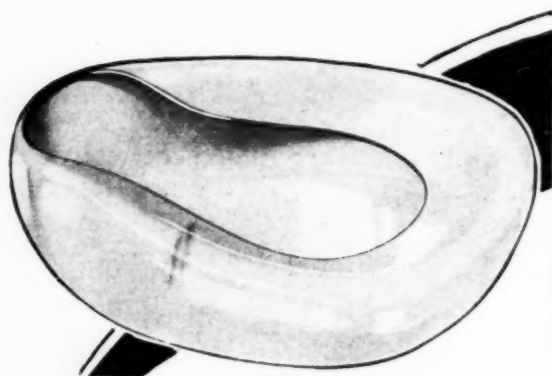
Artistic wood furniture radiates a cheery, home-like atmosphere that conquers the fear and dread of hospital patients. Add to the natural beauty of wood, the skill of Hill-Rom master designers and you have a fair mind's picture of Hill-Rom furniture.

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BATESVILLE, INDIANA

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As Distributors of Vollrath Ware we have been more than pleased with the many reports of complete satisfaction we have received from customers who have purchased it in preference to cheaper grades. So now it is a real pleasure to persuade others to replace worn and chipped utensils with this good enamel ware. We realize that it is slightly higher priced but we also know from experience that in the long run it is more economical for hospital service.



Our catalog illustrates and describes not only a full line of Vollrath Ware but also a complete line of Hospital Equipment—80 pages of Standard Merchandise at Wholesale Prices. You should have a copy for reference — and comparison. WILL ROSS, INC., 459 E. Water Street, Milwaukee, Wis.

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ABSORBENT**

now equipped with an air break funnel located in the waste piping below the extreme bottom of the sterilizer. Its function is obviously to prevent any backing up, even under suction, of waste matter into the sterilizer. The creation of even a high degree of vacuum in the sterilizer and the presence of a leaky valve will merely draw in air through the open break in the piping. Back pressure in the waste system—an improbable condition to be sure, but not unknown—would discharge the contents of the drainage pipe onto the floor and the air break thus would serve as the telltale of a dangerous condition that should be corrected at once.

New Appliance for Administering Solutions

The many small difficulties that in the past have beset hospital nurses in administering solutions by the Murphy drip method are largely avoided by a well worked out appliance recently marketed. This device resembles in shape the ordinary enema or Murphy drip can, but it has several vital improvements.

It has a double wall and is built on the vacuum bottle principle. It is finished inside and out with the new chromium type plating that does not tarnish. It is fitted with a fireproof glass gauge to show the nurse at a glance the exact amount of solution that has escaped. The coupling between the can, the gauge and the flexible tube leading to the patient is made of a durable, boilable and not readily breakable material. The can has a hanger to suspend it from a hook and is equipped with a snugly fitting rubber cover, the cover being chained to the container to prevent its loss.

Warm solutions put into the container lose heat very slowly, the temperature of the solution being maintained from one and a half to two hours.

This appliance is also recommended by its manufacturers for administering solutions intravenously and by hypodermoclysis. Every part of the appliance may be sterilized without injury by boiling or by pressure steam.

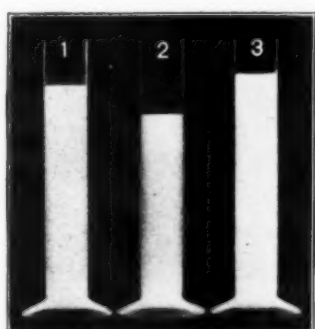
A summary of the points in favor of this piece of equipment includes its ability to keep solutions warm, its sanitary construction and the durability of the materials employed in its manufacture. While there is nothing to prevent loss of heat by the solution as it passes through the flexible tube from the appliance to the patient, it would appear that this objection could be controlled by putting the solution into the container at a temperature that would deliver it warm enough to the patient, and still keep the temperature of the solution in the container below a point that would, under any circumstances, cause a burn.

Curled Hair and Its Substitutes in Your Mattresses

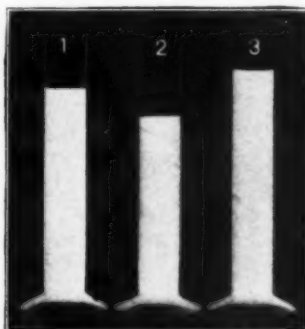
In a recent bulletin published by the Pennsylvania Department of Labor and Industry, Robert L. Houtz, chemist in the Bureau of Bedding and Upholstery, describes the various animal hairs and vegetable fibers used as mattress fillings and outlines the physical and chemical qualities possessed by these materials. That mattress fillings are frequently mislabeled is commonly known, and Mr. Houtz gives five examples of this, showing the percentages of the substitutes used.

Acme Bariummeal

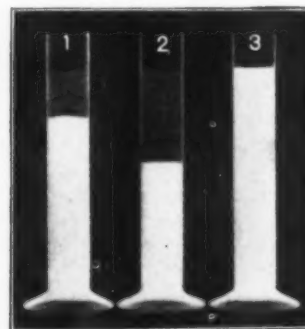
The unretouched radiographs on this page graphically illustrate the extraordinary suspension qualities of Acme Bariummeal. Tube No. 1 contains pure Barium Sulphate in water. Tube No. 2, equal quantity of a nationally known Barium Meal. Tube No. 3, equal quantity of Acme Bariummeal.



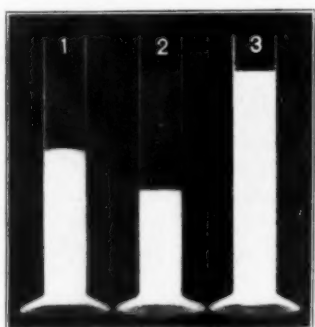
Ten minutes after mixing.



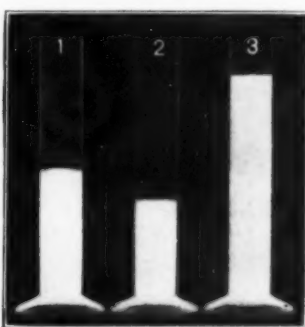
One hour after mixing.



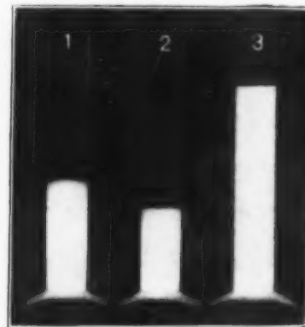
Two hours after mixing.



Four hours after mixing.

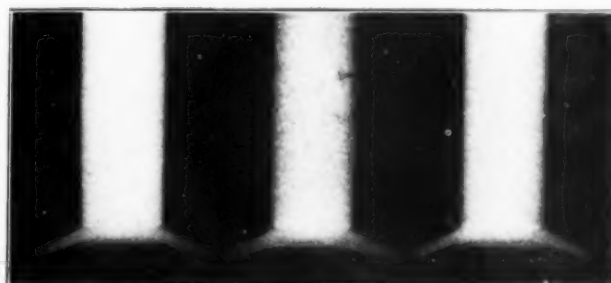


Six hours after mixing.



Twenty-four hours after mixing.

This unretouched radiograph illustrates the exceptionally uniform density of Acme Bariummeal, a factor of great diagnostic importance.



It mixes readily, is palatable and minimizes constipation tendencies. Available in 8 oz. cans (6 to the carton); 10 lb., 50 lb. and 100 lb. lots.

USE THIS COUPON



AT OUR RISK

Acme-International X-Ray Co.,
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Gentlemen: Please send me one carton containing six 8 oz. cans of your Bariummeal. I will try it and if thoroughly satisfied will send you my check for \$1.95. If not satisfied, it is understood that I may keep all six cans without any payment whatever.

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The objective for Fort Worth (Texas) Methodist Hospital campaign was \$125,000. Many said so much money could not be obtained.

Marts & Lundy organized and directed the campaign. Total subscriptions were \$375,000—three times the objective! Interest grew until one person gave \$75,000 and two pledged \$50,000 each—more than the total original objective.

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Refinishing and repair costs are a thing of the past when Wright Rubber Tile Floors are used. A rubber tile floor is permanent. With the help of our detailed, illustrated instructions any local carpenter or your handy man can make your installations without previous experience.

Our engineering department will furnish color and design recommendations; also estimate if you send us a rough drawing showing correct dimensions of the floor space and general color scheme of the walls. This service is Free. A chart of thirty color patterns will also be sent without cost or obligation. Write.

WRIGHT RUBBER PRODUCTS CO.
Dept. M H Racine, Wisconsin

Hospitals in particular use large amounts of hair for mattresses. Severe competitive bidding has caused the pure curled horse hair to be substituted by lower quality hairs, or vegetable fibers, somewhat resembling horse hair in appearance but decidedly inferior in service.

Curled horse hair makes a resilient, sanitary filling material for mattresses. The curling process converts the originally straight hairs into thousands of small spring-like curls. The heat treatment employed in this process makes the hair sanitary. It also gives the hair a permanent curl that lasts many years.

Under disguised names such as "Special Hair," "Amber Hair," "P. S. A.," "All Long Drawings," and "Boston Black," these cheaper products are often purchased by hospital authorities who think they are getting pure horse hair.

Of the five examples of mislabeling described, three are supposed to be all horse hair, the fourth, amber hair and the fifth, special hair. Examination revealed in the first sample, 20 per cent horse hair and 80 per cent hog hair; in the second, 70 per cent horse hair and 30 per cent goat hair; in the third, 70 per cent horse hair and 30 per cent vegetable fiber; in the fourth, 60 per cent hog hair and 40 per cent vegetable fiber; in the fifth, 75 per cent hog hair and 25 per cent vegetable fiber.

The characteristics that determine the values of various hairs and fibers as mattress fillers are their resiliency, brittleness, durability, length and their ability to retain a curl. Of all the materials tested, horse hair seems to meet these qualifications best.

How Hairs Are Tested

A laboratory testing device has been built in order to check up the physical qualities of individual hairs, and to compare them with standards made from new hairs. It consists of a mechanism that clamps the hair at each end. Tension is placed upon the one end, thus causing the hair to stretch and later to break. Accurate weights record this breaking point in grams. This is called the tensile strength. The stretch is measured in millimeters. Calculated on the basis of unit length, this tells the resilience.

By use of this apparatus the laboratory is able to tell damaged hair from new, strong hair from weak, and "lively" hair from dead. An approximation can be derived, too, as to whether hair of a certain test would be of high, medium or low quality, provided, of course, it is always compared with a sample of new hair of the same type or class.

Chemical tests have been devised by means of which real hair can be detected and separated from imitations. Hair contains keratin, which is soluble in boiling alkaline solutions, so that by boiling the filling in a caustic soda solution the animal fibers will be entirely dissolved and only the vegetable fibers will remain. Selective dyes may be used if a test is desired in which neither hair nor fiber is destroyed.

One of the best selective dyes is magenta which is first decolorized with caustic soda. When the mixture is boiled in this solution, then immersed in water acidulated with acetic acid, all animal fibers, such as hair, acquire a deep pink color while the vegetable fibers remain colorless. Other dyes that are readily absorbed by animal fibers only are aniline violet, fuchsine and boiling picric acid.

When hospital buyers can determine for themselves what quality filling is used in their mattresses, then manufacturers will realize that if their product is to be subjected to a test they must refrain from the use of substitutes for horse hair and do their utmost to provide the best quality of horse hair.